

JHS RESEARCH REQUEST FORM

PACS IMAGES

Email form to: Hansell.rodriquez@jhs-miami.org



Study approved for images by JHS Office of Research

REQUESTED BY:

Name: _____ Date: _____
Department: _____ Phone number/email address: _____
Special Instructions (e.g. de-identify PHI, Study ID): _____

BILLING INFORMATION

Billing Contact Person: _____ **PI NAME:** _____ **IRB #:** _____

Department: _____ Phone #: _____

Billing Address: Sponsored Program Specialist

Jackson Health System:

Approved by: _____

Request: Please provide following patient list. The fee (\$20) for copies of images is per exam **NOT** per patient. Allow _____ business days depending on the extent of the request and current staffing constraints.

No.	MRN#	DOB	Image Description	Date of Service	Fee
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