X-RAY REQUEST AND RELEASE FORM

Date: ____/____/____

Patient Name: _____

Requested by (if other then the patient): _____

Relationship to Patient: _____

Exam Date(s) Requested: _____

X-Ray(s) to be Sent/Faxed to: _____

_____

I _____ authorize the release of the X-Rays(s) requested above.

_____

Signature Date