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X-ray Release Form

PLEASE FILL OUT ENTIRE FORM
PLEASE PRINT NEATLY

Date requested:_____

Patient: _____ Account number: _____

Chart Number: _____ Date of Birth: _____ Phone number: _____

Requester's relationship to patient: _____

Name of who will pick up the X-rays and relationship to patient: _____

Treating Physician: _____ Body part of X-Ray: _____ Number of images: _____

Reason films are requested: _____

Doctor receiving the X-rays: _____

Address of doctor - street: _____ city: _____ state: _____

Type of doctor: _____ Phone number of doctor: _____

Cost of burning images to CD: $10	Cost of printing images to paper: $5
_____cash _____check _____credit card	Total charge $_____

Signature:_____ Date:_____