REQUEST TO DUPLICATE FILMS

Name of Patient: _____ Acct #:_____

Date: _____ Time: _____ AM/PM

COPY NEEDED BY: □ STAT □ NEXT DAY

REQUESTED BY: □ REFERRING PHYSICIAN
□ PATIENT
□ LEGAL

EXAM TYPE: □ ULTRASOUND □ MRI □ CT □ XRAY □ FLUORO

DATE OF EXAM: _____ _____

_____ _____

_____ _____

FILMS/CD ARE TO:

□ Be picked up by patient on _____

□ Be messengered to MD office: _____

_____
(address)

□ Be mailed to patient at: _____

_____
(address)

Release Authorization For Written Reports & Films/CDs

I, _____, hereby authorize Eastside Diagnostic Imaging, PLLC to release copies of any written reports and/or images pertaining to the procedures listed above to: □ myself □ my physician, _____
□ other _____

Signature of patient: _____ Date _____

Signature of other than patient: _____

Witness: _____