



CONSENT TO RELEASE X-RAYS

Name: _____ DOB: _____

Address: _____

Telephone: _____ XR #: _____

Please specify body part _____ RT ____ LT ____

Approximate date x-rays were taken _____

X-rays to be picked up? Yes if so, when?

No

*****Please note that it may take 7-14 days to receive xrays by mail.***

X-rays to be sent to: _____

If x-rays being sent to another physician or facility, did we refer you? Yes No

If any charges occur for the copying of x-rays we will contact you.

Date

Signature (Patient or responsible adult)

Relationship if not patient