Patient Name:_____

Patient DOB:____/____/____Patient Phone:( ) ____-_____

Request:

- ☐ **Films**
- ☐ **CD**
- ☐ **Report**

Type of Film:_____ Date of Service: ____/____/____

Pick Up Date: ____/____/____Time: ____:____

Mail Recipient Address: _____

Deliver To:_____

Date to Be Delivered:____/____/____

Released To:

Patient

Attorney

Physicians Office: _____

Other:_____

Request taken By:_____ Date: ____/____/____ Time: ____:____

Patient Signature:_____ Date: _____

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