X-RAY REQUEST AND RELEASE FORM

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Date: ____/____/____

Patient Name: _____

Requested by (if other than the patient): _____

Relationship to Patient: _____

Exam Date(s) Requested: _____

X-Ray(s) to be Sent to (Email address): _____

_____

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

_____

Signature Date