

# 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