Film Release Form

X-RAY # __________ TODAY'S DATE ____________________

PLEASE PRINT

PATIENT'S NAME ______________________________
Last First

PATIENT'S DATE OF ____________________

HOME PHONE ( )_________________________

I am taking these X-rays to:

WORK PHONE ( )__________________________

DOCTOR _______________________________________

DOCTOR'S PHONE ( )_______________________

DOCTOR'S ADDRESS_____________________________

CITY__________________________ STATE____

In borrowing these original radiographs, I understand that they are the sole property of Laurel Radiology Services, where they are maintained for my benefit.

I am aware that I am responsible for their safe return.

SIGNATURE___________________ RELATIONSHIP_________________________________

FOR OFFICE USE ONLY

PATIENT'S LAST DATE OF SERVICE

MONTH____

YEAR____

OFFICE____

DATE FILMS RETURNED______________

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