AUTHORIZATION TO RELEASE X-RAYS

PATIENT'S NAME: ____

D.O.B: _____________________________________

RECORD #: _____________________________________

X-RAY COPIES RELEASED TO: ___________________________________

____

____

We are pleased to provide you with copies of your x-rays. They are to be used only by a licensed physician in consultation to facilitate the treatment and diagnosis of your care.

The original films are part of your permanent record. You do not have to return these copies provided to you per your request.

____
__ **(Signature of patient)** **(Date)**

____
Witness

_________ **Date of x-rays**

__________ **Noted in chart & EMR**