



REQUEST FOR RELEASE OF DIAGNOSTIC FILMS

Re: Patient: _____ Home Phone: _____
Date Of Birth: _____ Other Phone: _____
Patient SSN: _____

Purpose Of Request: Second Opinion
 Continuation Of My Treatment For Services Ordered By Physician
 Transfer Of My Care To Another Provider
 For My Attorney
 Other _____

Diagnostic Film Requested:

X-Rays: As your healthcare provider, we are legally responsible for your medical records. We must maintain a permanent record of your x-rays in our files. We are happy to provide you with a copy of the x-rays in our files. **For the service of copying your radiology films, we assess a fee of \$10.00. This fee must be paid in advance.**

Please advise which x-rays you require (body part): _____

X-rays will be copied on Thursdays of each week. Therefore, your films will be ready for pickup on the Friday after your x-rays are requested. Since the x-rays provided to you are copies, it is not necessary to return these films to our facility.

MRIs: Our office does not assess a fee to provide your MRI films, since the MRI films in our files are copies from the facility which performed your MRI. However, your MRI films must be returned to our office within thirty (30 days). Your films should be returned to:

Alliance Orthopaedics & Sports Medicine
5040 Snapfinger Woods Drive Suite 206
Decatur, Georgia 30035

By signing below, I acknowledge and agree to the above conditions.

Signature of Patient Or Legal Guardian

Date

For Office Use Only:

Date Payment Received: _____

Amount Paid: _____

MD Approval: _____