



## 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-Ray Films: 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 \$20.00. (In accordance with WC Fee schedule, we assess a fee of \$9.50 to WC patients) 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.

MRI Films: 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.

X-Rays or MRI on Disk: If you brought in a disk containing images of your x-rays or MRI scan, then our office does not assess a fee to provide the disk to you. However, the disk must be returned to our office within thirty (30) days.

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: \_\_\_\_\_

