RADIOLOGY ASSOCIATES

Name of Patient:_____RA/Acct #:_____

Date:_____ Time:_____AM/PM

COPY NEEDED BY: ☐ STAT ☐ NEXT DAY

REQUESTED BY: ☐ REFERRING PHYSICIAN
☐ PATIENT

EXAM TYPE: ☐ Ultrasound ☐ MRI ☐ CT ☐Xray ☐ FLUORO ☐ PET ☐ OTHER

DATE of EXAM: _____ _____

_____ _____

_____ _____

FILMS/CD ARE TO:

☐ Be picked up by patient on _____

☐ Be messengered to MD office:_____

_____Phone #:_____
Address

☐ Be Mailed to patient at:_____

_____
Address

Release Authorizatio For Written Reports & Films/CDs

I,_____, hereby authorize Radiology Associates of Tarrant

County, PA. to release copies of any written reports and images pertaining to the procedure list above to ☐ myself ☐ my physician. _____
☐ other:_____

Signature of patient:_____Date:_____

Signature of other than patient:_____Witness:_____