doctors for adults

Internal Medicine of Griffin

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RELEASE FOR X-RAY'S

NAME: _____ _____
(PLEASE PRINT FULL NAME) **(DOB)**

_____
(PATIENT'S SIGNATURE)

_____
(DATE)

HOW MANY X-RAY'S: _____

WHICH X-RAY'S NEEDED: _____

DATE TO BE PICKED UP: _____

APPOINTMENT WITH: _____

ORIGINAL FILMS
MUST BE RETURNED