

doctors for adults

Internal
Medicine
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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