Records Release Request

I _____ am requesting duplicate x-rays for:

_____

_____

_____

_____

Reason for request:

☐ Going to a PPO ☐ Moving out of the area
☐ Dissatisfied with service ☐ Dissatisfied with billing
☐ Other_____

I understand that a duplication charge of $25 per patient will apply.

Once duplication is completed I would like the records to be:

☐ Mailed to:_____

_____

_____

☐ Placed on hold for pick-up on _____.

_____	_____	_____
Signature	Printed Name	Date