Receipt of X-Rays and/or Records

Patient Name _____ **Date** _____

Account #: _____

Doctor Name and Address _____

_____

I hereby state that I have requested the release of the medical x-ray films and/or other records of _____ which are currently the part of the patient records files held by _____

I acknowledge the receipt of the aforementioned records and associated documents, and I fully discharge _____ from any liability that my arise as a consequence of their release.

Signature: _____

Printed Name: _____

Witnessed By: _____

Printed Name: _____