NORTH DOVER
RADIOLOGY

DISC AND FILM RELEASE

Patient name: _____

Date of Scan(s): _____

Type of Scan(s): _____

Previous films brought in for comparison (yes) or (no)

I _____ hereby authorize North Dover Radiology, located at 1215 Route 70 West, Suite 1002-1003, Lakewood NJ, to release my set of films or an electronic copy on disk, to me, so that I can keep my films or disk, as part of my medical record for future reference.

I also hereby release North Dover Radiology from any and all legal responsibility or liability that may arise from release of these films.

For any additional disc or films a fee will be charged. The fee for a disc will be $25.00 and films will cost $75.00.

I hereby authorize North Dover Radiology to release the finalized report to the referring doctor. As well as **ANY** doctor or **ONLY** the referring doctor. Please circle ANY or Only.

_____ Date: _____

Signature of patient