NORTH DOVER RADIOLOGY

1215 Route 70 West
Suite 1002-1003
Lakewood, NJ 08701
732-370-9902

MEDICAL RELEASE FORM

Patient name: _____ **Date of Birth:** _____

Type of Scan(s):_____ **Date of Scan**: _____

I am hereby authorized the following doctors/attorney's permission to my finalized report for ***TODAY'S EXAMS ONLY.***

Please release the following report to the following doctors/attorney's:

Doctor Name:	
Address:	
Phone #	
Fax #	

Doctor Name:	
Address:	
Phone #	
Fax #	

Attorney Name:	
Address:	
Phone #	
Fax #	

Patient/Guardian Signature: _____ **Date:** _____