



NORTH DOVER
R A D I O L O G Y

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.

Signature of patient

Date: _____