New Hampshire ORTHOPAEDIC CENTER

CONSENT TO RELEASE X-RAYS

Name: _____ DOB:_____

Address:_____

Telephone: _____ XR #:_____

Please specify body part_____RT ☐ LT ☐

Approximate date x-rays were taken_____

X-rays to be picked up? ☐ Yes if so, where?

Please choose pick-up office Location

☐ No

***Please note that it may take 7-14 days to receive xrays by mail.**

X-rays to be sent to: _____

_____

_____

If x-rays being sent to another physician or facility, did we refer you? Yes☐ No☐

If any charges occur for the copying of x-rays we will contact you.

_____	_____	_____
Date	Signature (Patient or responsible adult)	Relationship if not patient