



Patient Name: _____

Date Released: _____

Medical Record Number: _____

Released By: _____

Baptist Health South Florida is happy to provide you with the x-ray films that you requested. However, please note that these films are released to you with the understanding that they are part of our records that we store and maintain for you. This service is provided to you should your physician need them at some future date for comparison purposes. If for any reasons these films are lost, we may not be able to reproduce them possibly causing further delays in your treatment.

Please note: You will be responsible for returning the films back to Baptist Health South Florida within 30 days. You are responsible for the quality and care of these films (including, but not limited to, storage of the films in a cool, dry atmosphere at all times).

I hereby request and authorize Baptist Health South Florida to release the films below. I hereby release and hold harmless Baptist Health South Florida, and Radiology Associates of South Florida, P.A. from any and all liability arising out of the release of the original films noted below.

Released to (print name and relationship to patient)

Requesting physician

Signature of person films released to

Physician's address (if known)

Address

Phone Number

Identification Number / Driver's license

INDICATE WHICH EXAMS ARE BEING RELEASED

(To be completed by the film Librarian)

- Mammography _____
- Abdomen _____
- Bone _____
- BE _____
- Chest _____
- Nuclear Med _____
- Head/Neck _____
- BCVI _____
- IVP _____
- G.I. _____
- Ultrasound _____
- Special _____
- SMHC _____
- CT _____
- Neuro CT _____
- MRI _____
- Neuro MRI _____

Comments _____

