PATIENT RECORDS REQUEST FORM

I hereby request a copy of current x-rays held by your office.

☐ I Will Pick Up My X-Rays

☐ Sent to : _____

_____

_____

Patient Name:	
Guardian (if applicable):	Relationship:
Patient Date of Birth:	Patient SS#:
Signature:	Date:

**Please allow 7-10 days for records to be duplicated, no exceptions.*