Patient Request for Transfer of X-Rays and/or Records

Date		Doctor Name			
Patient					
Address					
City		State		Zip Code	

I hereby authorize the release of my X-rays and associated records to the doctor/medical facility mentioned below, or a designated representative.

Release to:

Signature: ________________________________

Printed Name: ________________________________

Witnessed By: ________________________________

Printed Name: ________________________________

www.FreePrintableMedicalForms.com