MIDDLETOWN
MEDICAL IMAGING

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 Middletown Medical Imaging, located at 1275 Route 35 North, Middletown NJ 07748 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 Middletown Medical Imaging 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 Middletown Medical Imaging to release the finalized report to the referring doctor. As well as **ANY** doctor or **ONLY** the referring doctor. Please circle ANY or Only.

_____ Date: _____

Signature of patient