

Receipt of X-Rays and/or Records

Patient Name _____ **Date** _____

Account #: _____

Doctor Name and Address _____

I hereby state that I have requested the release of the medical x-ray films and/or other records of
_____ which are currently the part of the patient
records files held by _____

I acknowledge the receipt of the aforementioned records and associated documents, and I fully discharge
_____ from any liability that may arise as a
consequence of their release.

Signature: _____

Printed Name: _____

Witnessed By: _____

Printed Name: _____