PATIENT RELEASE OF X-RAYS FOR RADIOLOGIST

Brooke L. Gajeski, D.C., D.A.C.B.R.
SAFEGUARD **Radiology Interpretation Services**
6304 Thomas Ct., Prospect, KY 40059
Ph. (502)-961-0011 Fax (502) 213-0820
info@safeguardradiology.com

Referring Doctor/Office Name (Please Print):

Selection of Payment Method:

Check Payment Method (Doctor Only)

_____ Cash/Check/Credit Card

_____ PI Claim (call office for this selection)

_____

Patient Demographic Information:
(Please Print)

Patient Name_____

Parent/Guardian_____

DOB:_____ **Gender: M or F (circle one)**

Address_____

_____

City/State/Zip_____

Phone_____

Authorization to Release
Medical Information and X-rays

I hereby authorize the release of my x-rays and medical information necessary to SAFEGUARD RADIOLOGY for interpretation of my diagnostic imaging studies at the request of my physician,_____.

_____
Signature of Patient

Date
Signed:_____

For Referring Doctor's Use Only:

1. Symptoms/Comments:
(Attach copy of patient history/exam form or write patient complaint(s) and pertinent history here)