



## PATIENT REQUEST FOR RELEASE OF DIAGNOSTIC STUDIES

This is a request to obtain your diagnostic studies or to have your diagnostic studies sent to another physician. **It is recommended that you pick up your exams and take them to your appointment if possible.**

**\*\*If you have had surgery with one of the Peachtree Orthopaedic Clinic physicians we are unable to release the original films. You will need to pre-pay for copies of your films according to a fee schedule that will be provided to you by a representative of POC radiology.**

**\*\*\*If you are involved in a legal case or a worker's compensation case please have your attorney or nurse case manager contact us to obtain an invoice for film duplication.**

Please print the following information.

Patient Name: \_\_\_\_\_ Last 4 digits Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

POC Physician Seen: \_\_\_\_\_ POC Office location where you were seen: \_\_\_\_\_

**Receiving Party Information:** \_\_\_\_\_ Patient \_\_\_\_\_ Physician \_\_\_\_\_ Other: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**\*\*Please allow up to three (3) business days for all film copy requests to be processed**

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**ORIGINAL FILMS REMAIN THE PROPERTY OF PEACHTREE ORTHOPAEDIC CLINIC AND MUST BE RETURNED**