

X-RAY RELEASE LOAN FORM

Date _____

Patient's Name _____ Social Security # _____

X-ray file number _____ Copy of report enclosed Yes No

Number of Films: 8x10 _____ 10x12 _____ 7x17 _____ 14x17 _____ 14x36 _____

These films are copies of x-rays and do not need to be returned.

These films represent a part of the patient's permanent record at this office and are to be returned by mail directly to the address below by ____/____/____.

Mailing address: _____

City: _____ State: _____ Zip: _____

Taking to _____

Date returned _____

This will release Dr. _____ from all responsibility regarding these x-rays.

Patient Signature _____ Date _____

SPS INC.

231-924-3087

#0280801

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