



Patient Film / Image Copy Request

Print and Fax to (949)764-5861

Patient Name: _____

Daytime Phone #: _____

Birthdate: _____

Medical Record Number (if known): _____

Exam(s) Requested

X-ray CT MR US Exam Date _____ Requesting Physician _____
 NM Mammogram Other

X-ray CT MR US Exam Date _____ Requesting Physician _____
 NM Mammogram Other

Format requested

Check one:

CD
Free of charge

Film
Free if requesting physician is on staff at Hoag;
\$3.00 per sheet if not on staff at Hoag

Pick-up or Delivery Check one:

Pick-up

Patient must show ID

OR

If films/images are being picked up by someone else, please print, complete and sign the **Consent Release** below and submit this sheet at the time of pick-up.

Mail

Only mammograms can be mailed to patient's home. All other copies must be mailed to the requesting physician or hospital.

In order to mail your images, please print, complete and sign the **Consent Release** below and fax this sheet back to **(949) 764-5861** and call **(949) 764-5586** to confirm receipt of fax.

Mail to:

Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Please allow 10-15 working business days.

Consent Release

I authorize Hoag Memorial Hospital to release my film/images to _____

Patient Name (please print) _____

Patient Signature _____

Pick-up Designee Signature _____