



Hoag Radiology Film / Image Copy Request Form
Print and Fax to (949)764-5861

Physician Name: _____

Phone #: _____

Exam(s) Requested

Table with 4 columns: Patient name, Date of Birth, MRN#, Exam Requested. Includes multiple rows for data entry.

CD or Film
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

Images needed by _____

[] Mail To:

Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

If requesting physician is not the physician who ordered the exam(s), a patient consent is required. Please print and complete the Consent Release below and fax this sheet to Hoag Memorial Hospital at (949) 764-5861.

Consent Release

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

Patient Name (please print) _____

Patient Signature _____

Pick-up Designee Signature _____