

University Radiology Associates, LLP

Film Release

550 Harrison Center #105

Syracuse, New York 13202

464-7700

Date: _____ MRN#: _____

Patient's Name: _____

DOB: _____

**Authorization is hereby given to University Radiology Associates, LLP to release X-Rays to:
MD/Attorney/Insurance Carrier/Hospital/Other:**

Address: _____

Phone#: _____

| | | | |
|---------------|------------------|--------------------------------|----------|
| MRI _____ | Ultrasound _____ | _____ CD @ \$5.00 ea. | \$ _____ |
| CT Scan _____ | X-Ray _____ | Total Copies@\$10.00 1st sheet | |
| | | & \$8.00 ea add. Sheet _____ | |
| | | Total Charge: | \$ _____ |

Pick-up Date: _____ Special Instructions: _____

Mailing Date: _____

Please Note: These are original films and should be returned to this office within 14 days, or as soon as treatment is complete.

Signature of Patient or Representative

Date

Printed Name of Patient or Representative

Relationship to Pt.:

Address: _____

Phone# _____

Send form to the above address or fax it to: 464-7730

CHECKED BY: _____

Film release form