



The Imaging Center

REQUEST FOR COPIES

Please fill out request COMPLETELY and give to the person in charge of creating CDs and/or films***
24 Hour notice is required for all requests.

*In compliance with the HIPAA privacy act, photo identification is required for the release of images.

* Patient Name: _____ Unit #: _____

* Patient Date of Birth: _____ Phone #: _____

CT	MRI	FLORO/ X-RAY	US	BMD	BONE AGE	SCOLIO STUDY	BODY PART	DATE OF EXAM

* Request taken by: _____

* Requesting Office/MD: _____

* Person requesting CD: _____ Phone #: _____

*Today's Date & Time: _____

* Date & Time CD Needed: _____

Pt Pick-up*

Mailing Address

Overnight

Pick-up by (Name and relation to pt):*

*This person will be asked for photo ID

Name of person burning CD: _____

Films: _____

Report included on disk

CD Checked and Complete

***Films are printed only with specific
permission from a supervisor***

Of Copies (if more than one): _____

UPS Tracking #: _____