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Thomas W. Axelrad, M.D.

Imaging Request Form

Patient's Name:_____DOB:_____

☐ All Images

☐ Images from (date):_____ to (date):_____

(CD copy - $10.00 charge per CD for personal records, no charge if sent directly to outside physician.)

I hereby authorize the following healthcare to release my confidential medical information and records to the physician, person, facility listed below.

Medical Office:	**Self:**	**Other:**

☐ **Pick Up**

☐ **Mail**

Name:_____

Address: _____

City/State/ZIP: _____Phone:_____

Permission for further use or disclosure of this medical information is not granted unless another is obtained from me or unless such disclosure is specifically required or permitted by the law. A photocopy or facsimile of this authorization shall be considered as an effective and valid original document

Patient's Signature: _____ Today's Date: _____

CD paid: *(front desk use only)*

Yes:	***No:***

ID VERTIFIED BY:_____ *(front desk use only)*

This form expires 1 year after signed. MD's Initials:_____

Please fax this form to (707)-546-1897

03/09/2020