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REQUEST FOR X-RAY COPIES (CDS)

Fill out this form and return it to:

Shore Orthopaedic University Associates
X-Ray Department
24 MacArthur Blvd
Somers Point, NJ 08244
Attn: Lorraine/Eileen

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

PATIENT AUTHORIZATION:
I hereby authorize my medical x-ray records to be released

Patient Signature: _____ **Date:** _____
(Patient, Guardian or Authorized Representative)

Questions: Shore Orthopaedic X-Ray Dept. 609-927-1991 ext. 109