REQUEST FOR RECORDS RELEASE

JUST X-RAYS
244 N JACKSON AVE. SUITE 110
SAN JOSE, CA 95116
Phone: 408.272.2727
Fax: 408.272.2077

Requesting Physician's Name: _____NPI: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Dear "Just X-Rays Record Release Personnel": _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: _____

Birth date: _____ Social Security Number: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the Radiologist Evaluation Report in your file.

Please note X-Ray Films or Ultrasound images may be re-produced on a CD for an additional fee. As a value added service these images can be made accessible to you on a secure site at no charge.
You will need to be issued the login privileges by JUST X-RAYS administrators,

Thank you for expediting this request. Please send these records to our office address shown above.

_____ To be completed by Patient and witness _____

I hereby authorize the release of all necessary medical records to _____

Patient's Name : _____ Date: _____
(or legal guardian if patient is a minor)

Patient's Signature: _____ Date: _____
(or legal guardian if patient is a minor)

Patient's Address: _____ City: _____ State: __ ZIP Code: _____

Patient's Home Phone Number: _____Cell Phone Number: _____

Signature of Witness: _____ Printed Name : _____