

NEW HAMPSHIRE ORTHOPAEDIC CENTER

Tel: (603)883-0091 Fax: (603)818-3739

AUTHORIZATION FOR RELEASE OF RADIOLOGY FILMS

(Please note there is a separate authorization to release medical records)

Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Home

Work

Cell

What was the approximate date your film(s) were taken? _____

What type of film(s) are you looking to obtain? (i.e. Right Knee) _____

Signature of patient or legal representative

Date