Imaging Release Form

Date: _____

Patient Name: _____

Type of Films:

MRI's: _____

X-Ray's:_____

Date of Films: _____

This patient has taken his / her films out of the office of Active Orthopedics, L.L.C., and here by acknowledges that Active Orthopedics, L.L.C. is no longer responsible for the above films.

Patient Signature: _____