NEOS

Northeast Orthopaedic Alliance

300 Birnie Avenue Suite 201, Springfield MA 01107-1107

RADIOLOGY FILM RELEASE FORM

PATIENT NAME : _____ **DOB:** _____

BODY PART: _____

FILMS GOING TO: _____

_____

_____

SIGNATURE

DATE

You have requested copies of your X-Ray Films.

The cost of copies is $10.00 for one CD containing all requested films.

Please complete the above release form, enclose your check made payable to Northeast Orthopaedic Alliance and Mail to:

Radiology Department

Northeast Orthopaedic Alliance

300 Birnie Avenue- Suite 201

Springfield, MA 01107

Upon receipt of this release and your check, we will mail your x-ray CD to the above listed address.