STONY BROOK UNIVERSITY MEDICAL CENTER
Stony Brook, N.Y. 11794

AUTHORIZATION FOR DUPLICATION OF DIGITAL IMAGES

Copies of x-rays may be obtained from the Radiology File Room. Patient authorization must be given in writing. For inquires please call 631-638-0649, Fax-631-638-0643.

✸ THIS FORM MUST BE SIGNED TO BE PROCESSED ✸

TO BE COMPLETED BY PATIENT

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

BILL TO NAME: _____ PHONE: ( )_____

ADDRESS: _____

TYPE OF X-RAYS:_____DATE OF EXAM: _____

_____DATE OF EXAM: _____

_____DATE OF EXAM: _____

MAIL TO: _____ Will Pick Up? ☐ Yes ☐ No

_____

_____

RECEIVED_____COPIES RECIPIENT SIGNATURE: _____

PATIENT SIGNATURE: _____

I UNDERSTAND THERE IS A $15.00 FEE PER EACH CD.
NOTE: SOME EXAMS REQUIRE MULTIPLE FILMS AT $15.00 EACH.

Please be advised no studies will be duplicated prior to authorization.

PATENT NO. 1146084 ___ ___ ___ ___ ___ ___ Medical Record No. :_____

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All Payments Should Be Made Out to University Hospital Business Office.

DISTRIBUTION: White- File Room; Yellow- Billing; Pink- Patient