

ACC#: _____
MR#: _____

FILM AND REPORT REQUEST FORM

I am requesting the following: Radiologist's Report CD Film Copy
(Please check all that apply)

Request may be faxed to:
GCM-Suburban Imaging: 301.897.7333
Rockville: 301.762.2259
Chevy Chase: 301.907.0340
1145-19th St: 202.293.3086

Patient Name: _____

Patient Date of Birth: _____ Home Telephone #: _____

Work Telephone #: _____ Cell Phone #: _____

Type of Exam _____ Date _____

Type of Exam _____ Date _____

Type of Exam _____ Date _____

PLEASE CHECK ONE OF THE DELIVERY OPTIONS BELOW:

____ 1. Please send report(s) and/or CD and/or film copies to the following address:

____ 2. I will pick up my report(s) and/or CD and/or film copies on Date: _____

____ 3. Please fax my report(s) to the following fax #: _____

Referring Physician: _____ Phone #: _____

Patients Please Note: Other than to your physician(s), reports are mailed to your verified address on file. Results may be faxed to your personal fax number only with a verified signed request form matching your signature on file. If results are to be released to someone other than you, a signed request from you stating to whom the records may be released is required. A photo ID of the named patient representative will be required prior to the release of your information. There is no charge for the first copy of your exam(s). A fee is charged for additional copies.

Patient Signature _____ **Date** _____