Harbor-UCLA
MEDICAL CENTER

Los Angeles County
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1000 West Carson Street
Torrance, CA 90509

Tel: (310) 222- XXXX
Fax: (310) XXX-XXXX

# FILM REQUEST FORM

Patient Last Name _____ First Name _____ Middle Initial _____

Patient's Medical Record / HH Number. _____

REQUEST DATE: _____

RADIOLOGY FILM/PROCEDURE DATE/NAME:

- No copies are made until the medical record release form is completed.
- Patients paying for personal copies must present a cashier's receipt to radiology file room before any copies are made. Cashier's receipt Number:_____

This is your authority to release copies of my original x-rays as specified to:

Physician / Hospital Name _____

Physician / Hospital Street Address _____

Physician / Hospital City _____ State _____ Zip Code _____

Physician Telephone _____

Patient Signature / Date _____ Patient Telephone Number _____

*Parent Signature / Date _____

*Parent Signature if patient unwed minor. If one person has full legal custody, so state

2. Physician's signatures are required for patients who are not mentally competent or incapacitated and are transferring to another hospital.

Witnessed by:

1_____ 2_____

ACKNOWLEDGEMENT OF RADIOLOGY FILM RECEIPT

Signature of Person Receiving Films _____ Patient Medical Record Number _____

Number of Films Sheets /CD's Received _____ Date Received _____

Health Services
www.dhs.lacounty.gov