DIAGNOSTIC IMAGING CONSULTANTS

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# \*\*Please print and complete form for each patient and include with films

#

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_ Sex \_\_\_M\_\_\_F

# Films being sent (type of study)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# NUMBER OF IMAGES SENT: 6 5 4 3 2 1

**DATE TAKEN:\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Medical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# 35490

# BILL DR.

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize Spinal Logic Chiropractic to release my Xrays to Diagnostic Imaging for review and report of any and all medical diagnosis. I understand my information will not be shared with any other entity without my permission.**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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