Capital Imaging

4927 Auburn Avenue, Suite T-25
Bethesda, Maryland 20814
Phone (301)718-3411 Fax (301) 718-0805

Date: _____

Patient Name: _____

Films and/or a CD will be released to you after your procedure.

Your follow up appointment with your physician is scheduled:

____ Date: _____ ____Have not scheduled appointment

Please email me a copy of my report to the following email address:

_____

I understand that when my email is released that my email address may or may not have the appropriate security to be considered HIPAA compliant but I still choose to have my report email. Be advised your email will not be sent prior to three business days.

If you wish to have your reports mailed, please notify the staff and we will give you an envelope to self address.

Please send the radiology report to the following additional physicians:

Name	Fax Number
_____	_____
_____	_____
_____	_____
_____	_____

I understand that if **additional** copies of films/CDs are requested there will be an additional charge. Studies generated on a CD will cost $25.00. If films are printed, the charge will be $15.00 per sheet. The payment will be collected prior to printing/burning the images.

Signature of patient: _____

Note: If your doctor doesn't need your films for surgery or further evaluation, make sure you keep your films for future comparisons.