



Image Request Form

Please allow at least one business day following submission of this form for us to process your request. Thank you!

Date: _____

Patient Name: _____ Date of Birth: _____

Date of Exam(s): _____ Type of Exam: MRI CT US
(circle as many as apply)

Circle all that
Apply per request: CD CD/Paper Images Films Paper Images Report

Requested Pick-up Date: _____ Approx. Time: _____

Mail to: _____

Please note – payment for requested materials must be received prior to the mail date or at time of pick up. We accept VISA, MasterCard, Discover, Check, or Cash. Please call our office to arrange payment.

*****Applicable charges for reproduction of CD and/or films*****

| | |
|---------|----------------------------------|
| \$50.00 | Hardcopy Films/per Exam |
| \$30.00 | CD and Paper Images/per Exam |
| \$20.00 | CD only For All Dates of Service |

*****IAC USE ONLY*****

Completed By: _____ Technologist: _____

Date/Time Completed: _____