STONY BROOK UNIVERSITY MEDICAL CENTER
Stony Brook, N.Y. 11794

# AUTHORIZATION FOR DUPLICATION OF DIGITAL IMAGES

**Copies of x-rays may be obtained from the Radiology File Room. Patient authorization must be given in writing. For inquires please call 631-638-0649, Fax-631-638-0643.**

**✸ THIS FORM MUST BE SIGNED TO BE PROCESSED ✸**

## TO BE COMPLETED BY PATIENT

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

BILL TO NAME: _____ PHONE: ( )_____

ADDRESS: _____

TYPE OF X-RAYS:_____DATE OF EXAM: _____

_____DATE OF EXAM: _____

_____DATE OF EXAM: _____

MAIL TO: _____ Will Pick Up? ☐ Yes ☐ No

_____

_____

RECEIVED_____COPIES RECIPIENT SIGNATURE: _____

PATIENT SIGNATURE: _____

**I UNDERSTAND THERE IS A $11.00 FEE PER EACH CD.**
**NOTE: SOME EXAMS REQUIRE MULTIPLE FILMS AT $11.00 EACH.**

**Please be advised no studies will be duplicated prior to authorization.**

PATENT NO. 1146084 ___ ___ ___ ___ ___ ___ Medical Record No. :_____

**PRIVACY NOTICE:** This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivery of the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

**All Payments Should Be Made Out to University Hospital Business Office.**



**DISTRIBUTION: White- File Room; Yellow- Billing; Pink- Patient**