Film Duplication Request Form

Date of Request: _____/_____/_____

Patient ID# _____

Patient Name (First & Last Name):	**Patient Date of Birth:**
Film Duplication Being Requested By?	**Contact Phone Number:**

****Pre-payment is required before films and/or CD will be duplicated****

Film pricing is $80.00 per study and CD pricing is $25.00 per CD
(Maximum of two studies per CD)

Scanner:	Test:	Date of Service:	Indicate Films or CD Below:
			☐ Films ☐ CD
			☐ Films ☐ CD
			☐ Films ☐ CD
			☐ Films ☐ CD
			☐ Films ☐ CD

Total amount due: $ _____

Delivery Method:

☐ **Mail –If address is not provided on this form, there will be a delay in the mailing process.**

Street Address: _____

City: _____ State _____ Zip Code:_____

☐ **Patient to Pick Up**

☐ **Rep to deliver**

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