

## **Patient Film and Report Request**

Patient Name		
		Zip Code
Phone Number	Date of Birth	Last Four SSN #
Exam #1		Exam Date
Exam #2		Exam Date
Exam #3		Exam Date
	Fax to the below:	
City		State Zip
Phone	Fax _	
Authorizing Signature		Date
Relationship to Patient		
•	, , ,	30, or PO Box 1535, Tacoma WA 98401 ion. To protect your privacy, we recommend
Staff Member		
Date	Patient MRN	