

# BaylorClinic

## RELEASE OF RADIOLOGY FILM/REPORTS

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

From: \_\_\_\_\_  
(Signature of treating/consulting physician or designee)

Date Requested: \_\_\_\_\_

Please send a copy of all radiology films/reports and/or records of the following patient to:

Diagnostic Services  
BaylorClinic  
6620 Main Street, Suite 1275  
Houston, Texas, 77030  
Telephone: 713-798-2300.  
Fax: 713-798-2302

Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

*(The preferred method for reports would be CD Rom disc.)*