

**PATIENT COMPACT DISC RELEASE FORM**

**Date:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**DIAGNOSTIC TEST (S):** \_\_\_\_\_

**DATE OF SERVICE (S):** \_\_\_\_\_

**I hereby acknowledge the release of the CD pertaining to the above referenced diagnostic test(s) as the doctor's copy.**

**Patients must show a form of government issued ID for the release of a CD.**

**PATIENT SIGNATURE:** \_\_\_\_\_

**PATIENT TELEPHONE NUMBER:** \_\_\_\_\_

**Check if applicable:**

**Ordering MD is requesting the CD**

**Signature of Ordering/ Requesting Physician:** \_\_\_\_\_

**Patient permission given for another person to pick-up CD**

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**I have checked the requesting patients ID** \_\_\_\_\_