fortiusclinic

Electronic Imaging Transfer Request Form

Patients Name

Date of Birth

Address

Reason for Request

Date of Imaging

Type of Imaging and Body Parts

Person Receiving Images

Receiving E-mail Address

Contact Phone Number

Contact Address

Please note, the form MUST be signed in order to process the request

Patients signature

I confirm that I, the individual making the request, have sought the consent of the patient to release their images to the address declared above

Signature

Date

Please return to
Radiographers, Fortius Clinic 17
Fitzhardinge Street London
W1H 6EQ

Alternatively please scan/photograph and email to
marylebone radiographer@fortiusclinic.com