fortiusclinic

# Electronic Imaging Transfer Request Form

Patient's 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

patient's 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
**radiographers@fortiusclinic.com**