

Imaging Disc Request Form

Patients Name

Date of Birth

Address

Reason for Request

Date of Imaging

Type of Imaging and Body Parts

Person Receiving Images

Delivery Address for Disc

Number of Discs Required

I, the patient, consent to my images being released as above. *Please note, the form MUST be signed in order to process the request.*

Patients signature

Date

**If you are NOT the patient please complete the below.**

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 completed forms via email to*** [***pacsadmin@fortiusclinic.com***](mailto:pacsadmin@fortiusclinic.com) ***or give to reception.***

***If you would like to post the completed form please address to:***

***Pacs Admin Team, 17 Fitzhardinge Street, London, W1H 6EQ***