

Sentara Northern Virginia Medical Center

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Department of Radiology

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Authorization of Record Release

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To whom it may concern:		
Sentara Northern Virginia	Medical Center's Radiology Departme	ent is requesting radiographs and the
		ne file room will return the films within
	indicated. Thank you for your cooper	
ou days, diffess otherwise	indicated. Thank you for your cooper	ation.
Patients Name:		
	L The state of the	
Date of Birth:	SSN:	
Address:	Late & Till 1	
Home Phone:		
Work Phone:		
Name of exam being reque	ested:	
Nata of Camilan		
Date of Service:		
	Signature of Patient	

(If the patient is a minor, parent's or legal guardian's signature)