



“Our **mission** is to provide high quality, accessible, and **affordable** MRI services for **economical** minded consumers in a **fast, friendly, and professional** manner.”

FILM REQUEST

TO: _____

PATIENT NAME: _____

DOB: _____

TYPE OF STUDY:

- CT/MRI _____
- US _____
- X-RAY _____
- OTHER _____

Can you please:

- Fax Report Only
- Send CD and Report

DATE NEEDED: _____ FAXED ON: _____

HIPPA DOES NOT APPLY

Assigned medical release is not required from the patient pursuant to HIPPA regulation §164.512

THANK YOU!

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