

Patient Name.: _____ Date of Birth: _____ SSN: _____

_____ please release my medical records to **Reno Diagnostic Centers**.

Please fax my reports to **(775) 323-2193**.

I also request that you send copies of the following images to:

Reno Diagnostic Centers
590 Eureka Avenue
Reno, Nevada 89512

Exam Date	Exam Type	Film / CD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Patient or Legal Guardian

Date

Relationship to Patient