If you had imaging done, please complete and sign the form below.
If you have not had imaging done, please skip this page.
Thank you.

AUTHORIZATION FOR REQUEST OF MRI, CT-SCAN OR X-RAY RESULTS

IMAGING FACILITY NAME: ____

Fax Number: (   ) ____________-________________

PATIENT'S NAME and DOB: ____

Case Number: ________________________

ADDITIONAL INFORMATION: ____________________________________

I, the udnersigned, hereby grant permission for the release of my imaging report(s)/results to North Shore Physical Therapy.

Please fax it to (circle your location) attention to: ____

Marblehead Office: 781-639-2060

Peabody Office: 978-826-5297

Patient's Signature: ____

Today's Date:

11/07/2022

Physical Therapy Patient. Please respond ASAP.

Thank you for your time and cooperation.