Primary Care Medical Center, PLLC
15444 Dedeaux Road, Suite B
Gulfport, MS 39503
Phone: (228) 832-9038 Fax: (228) 832-9990
Email: info@primarycaregpt.com
Office Hours: 8:00am-5:00pm Monday-Friday

PATIENT X-RAY RELEASE FORM

I, _____ hereby authorize and request the release of

x-rays taken of me to:

Name _____

DOB _____ Last four of the SSN# _____

Address _____

City/State/Zip _____ Phone _____

I understand that these x-rays are part of original medical records which belong to Primary Care Medical Center of Gulfport, PLLC. I accept responsibility for their care and prompt return.

Patient's signature _____

Date _____

Released by _____

Date _____