



IMAGE REQUEST

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Please complete the following information. Please print clearly.

Patient Name _____

DOB: _____

Mailing Address: _____

Telephone: _____

EXAM TYPE MRI CT U/S MAMMOGRAM X-RAY DEXA
Please circle

I would like a copy of my (please circle):

Images Report Images & Report

I will pick up Please mail to me Please mail to my clinician

If your physician would like a copy of your exam report faxed, please have their office call 360-493-4600.

Clinician Name _____
Clinician Address _____
Clinician Fax #: _____

NOTES

Patient Signature: _____ **Date:** _____

PLEASE FAX TO: (360) 493-5326