RADIOLOGY ASSOCIATES OF
VENICE & ENGLEWOOD

M.E. BAGA, MD
E.M. VIHLEN, MD
E.A. DIENES, MD
G.D. WRIGHT, MD
S.L. SELVA, MD
P.M. MIHM, MD
C.S. GORDON, MD
C.T. REIHELD, MD
C.J. DAVENPORT, MD
K.A. RUZEK, MD
M. KIMBALL, DIRECTOR
512-516 Nokomis Avenue South, Venice, FL 34285
(941) 488-7781
900 Pine Street, Englewood, FL 34223
(941) 475-5471


# REQUEST FOR OUTSIDE FILMS/CDS/REPORTS

**I HEREBY AUTHORIZE RELEASE OF ANY OR ALL OF THE FILMS/CDS AND FINDINGS FOR:**

**PATIENT NAME:**____________________________________________

**DATE OF BIRTH** ________________**, AND DATE & TYPE OF EXAMINATION(S)**

______________________________________________________

______________________________________________________

**FROM:**

______________________________________________________

**Name of Hospital or Facility**

______________________________________________________

**Address**

______________________________________________________

**City, State, & ZIP code**

**TO: Radiology Associates of Venice & Englewood**
**Attention: Medical Records**
**512-516 Nokomis Avenue South**
**Venice, FL 34285**

**I WILL REQUEST THAT THE IMAGES BE RETURNED AS SOON AS POSSIBLE.**

________________________________________ __________

**Patient Signature** **Date**

**(If patient is unable to sign, guardian, parent, or authorized person may sign.)**

## PLEASE FILL OUT THIS FORM AND SEND TO THE OUTSIDE FACILITY.