MONUMENT & 9A IMAGING & DIAGNOSTIC CENTER
1201 MONUMENT RD, SUITE 101
JACKSONVILLE, FL 32225
P) (904) 855-0700
F) (904) 855-0739

I authorize _____ to release my radiology exams and reports to Monument 9A Imaging Center for comparison to my current exam.

Studies Requested: _____

_____

_____

_____

Patient's Name: _____

Date of Birth: _____ Social Security #: _____

_____ _____

Patient's Signature Date

- Please mail to the above address and confirm by phone or fax. Thank you

Facility phone # _____

Facility fax # _____