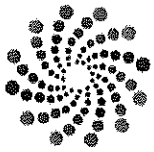

MONUMENT-9A
Imaging & Diagnostic Center

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CD RELEASE REQUEST

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TYPE OF STUDY: _____

DATE REQUESTED: _____

DATE NEEDED: _____

PT ACCT #: _____ **PT PHONE #:** _____

BY SIGNING THIS FORM, YOU UNDERSTAND THAT YOUR FIRST CD IS COMPLIMENTARY AND THERE WILL BE A $5.00 FEE FOR ANY NEW/ADDITIONAL CD.

SIGNATURE: _____ **DATE:** _____