EliteRAD
RADIOLOGY SERVICES

Elite2ndREAD Request Form

Today's Date: _____Contact: _____Email: _____

Business Name: _____

Business Address: _____

Phone: _____

Select Your Reports: *(Reports are $250 ea.)*

☐ **Lumbar** _____Second Opinion _____Comparison

☐ **Thoracic** _____Second Opinion _____Comparison

☐ **Cervical** _____Second Opinion _____Comparison

☐ **Other** _____ _____Second Opinion _____Comparison

☐ **Other** _____ _____Second Opinion _____Comparison

☐ **Other** _____ _____Second Opinion _____Comparison

Special Instructions:

_____

_____

Note: Payment must be included with request to avoid processing delays. Checks are made payable to EliteRad Radiology

Total Report Cost _____

_____
Authorization Name (Print)

_____ _____
Authorization Signature Date

Mail completed form, images, documents and payment to:

EliteRad Radiology
5840 Red Bug Lake Rd., Suite 185
Winter Springs, FL 32708