UNIVERSITY OF MICHIGAN HEALTH SYSTEMS
COPY SERVICE RELEASE FORM

I_____ of_____
Name Address

hereby request release of my radiology material described

as ALL X-RAY FILMS AS DESCRIBED ON THE ATTACHED SUBPOENA or LETTER REQUEST to

RECORDS DEPOSITION SERVICE, INC. of P.O. BOX 5054 SOUTHFIELD, MI 48086-5054
Name of record copy service Address of record copy service
(248) 357-3330
Record copy service phone number

I understand that the above record copy service will be solely responsible for the safe keeping and timely return of the material to the University of Michigan Health System (UMHS) Department of Radiology. If this record copy service does not return the material in good condition and in a timely manner, I understand that UMHS will not be responsible for any liability that may arise from the materials not being available.

Authorization signed by a legal representative must include a copy of the Guardianship papers for a Power of Attorney

Signed by:_____ Date_____
Patient, Parent, Legal Representative

Type of exam	Date of exam	# of Films

Films received _____(Date)

Name of record copy service_____

I acknowledge that the material was released to me in good condition. I understand that we will be solely responsible for the safekeeping of this material and must return the material to the University of Michigan Health System (UMHS) Department of Radiology within 7 days. I understand that we assume full responsibility for the safe transport and timely return of said materials in good condition.

Signed by:_____ _____
Agent for record copy service Date

_____ Films returned to file room: _____(Date)

_____ _____
File room (Mott/Main/Breast Imaging/MedSport) Signature