FAX BACK 815-756-7130

MRN:	Staff initials:	Date:

Midwest Orthopaedic INSTITUTE

RELEASE OF RADIOLOGY IMAGES/MEDICAL RECORDS

Patient Name:_____DOB:_____

IMAGES/MEDICAL RECORDS TO BE RELEASED:

☐ **XRAY IMAGES**	Body Part(s):	Date(s):
☐ **MRI IMAGES**	Body Part(s):	Date(s):
☐ **MEDICAL RECORDS**	Type of Records:	Date(s):

I authorize Midwest Orthopaedic Institute to Release my radiology images/medical records to the following party at the following address:

☐ **Hold images/medical records for pick up at Midwest Orthopaedic Institute**

Name of recipient_____Phone Number_____

☐ **Mail images** ☐ **Mail Records** ☐ **Fax Records** ☐ **Email records**_____

Name of recipient:_____Fax#_____

Address_____ City_____State____Zip_____

PURPOSE OF DISCLOSURE:

☐ Medical care ☐ Payment of claim/benefits ___Personal use
☐ legal investigation ☐ Other(please specify)_____

I understand that by signing this any and all records may be released and that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to the revocation. Unless otherwise specified, this consent will expire one year from the signed date.* ***Please note if additional copies of images are needed a $10.00 charge will apply. For Medical Records a second copy is $25.00.*

*****If you do not pick up your images within 30 days they will be destroyed and there will be a $10 charge for your next CD.***

_____ _____
Signature of patient/legally authorized representative ***Date***

_____ _____
Printed name of patient representative authorized to receive record ***Witness***

_____ _____
Signature of patient/legally authorized representative at time of pick-up ***Date/Time Picked Up***

Verification Provided: DL State ID MR Photo Verbal (DOB, Address, Last 4 SSN) Other: _____

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