FAX BACK 815-756-7130

MRN:	Staff initials:	Date:

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 medical records for pick up at Midwest Orthopaedic Institute**

Name of recipient________________________________Phone Number___________________

☐**Mail Records** ☐**Fax Records** ☐**CD ($10)** ☐**Email** _____________________________

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 a CD of images are needed a $10.00 charge will apply. For Medical Records a second copy is $25.00. Revised 4/2019*

____ ___________________________
Signature of patient/legally authorized representative ***Date***

____ ___________________________
Printed name of patient representative ***Witness***