NAME _____ DATE OF REQUEST_____

DATE OF BIRTH _____ ACCOUNT # _____

JEWETT ORTHOPAEDIC CLINIC

REQUEST FOR COPIES OF RADIOLOGY FILMS/CD

As a patient or as an authorized representative of a patient of Jewett Orthopaedic Clinic, you are entitled to a copy of your x-rays. You may also authorize release of your x-rays to other recipients. You understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. When received by the radiology personnel, your identity will be verified and your request will be processed. If you have any questions or concerns, please contact a Radiology Dept representative at (407)643-1283.

☐ I would like a **copy** of my x-rays. I understand there will be a fee **($10.00 per CD**) for copies unless provided directly to another medical facility for continued care. I understand that I will be required to pay the fee in full before I may obtain the copies.

Patient Name _____ Phone #_____

☐ Pick Up (Allow 48 hrs.) ☐ Mail to Patient's Address_____

_____

☐ Mail to Medical Facility (Allow 10 days) Name & Address of Medical Facility:_____

_____

Description of X-Ray studies to be copied (example: left knee x-rays, lumbar spine MRI, etc.):

_____

_____

Reason for request:☐ Medical Treatment **(Dr. Information is needed)**_____

_____ ☐ Insurance ☐ Legal **($10.00 per CD**)

☐ Other_____**($10.00 per CD) * If mailed prepayment is required***

This authorization expires 90 days from the date appearing below.

I understand that I may revoke this Authorization at any time by notifying the organization providing the information in writing, except to the extent that:

1. Action has been taken in reliance on the Authorization; or

2. If this Authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

By signing below, I acknowledge and agree to the above conditions.

DATE _____

_____ _____

SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)

PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

FOR OFFICE USE ONLY

Identity Verification: ☐ Driver's license ☐Other ID

# of Copies _____ @ $ _____per copy $ _____ Total Cost

☐ **Date Picked Up** _____.☐ **Date Mailed** _____