

Radiological Freedom of Information Agreement

I, _____, understand that x-rays may be necessary for my diagnostic workup and treatment plan. I have a right to check them out of the office should I desire to do so. I understand that any x-rays taken at this location are the property of the doctor's office.

If I choose to checkout my x-ray films, I may check the films out for fourteen (14) days. Films will not be sent through the mail; they must be picked up in person by the patient or legal guardian, according to HIPPA statutes. If I fail to return the x-ray films back to the office at 1445 Palatine Road, Hoffman Estates, IL 60192 during office hours, I understand that I(not my insurance company or other carrier) will be charged the full cost of x-rays, \$250.

By affixing my signature below, I agree to these terms.

Patient Signature

_____ Witness (staff only)

_____ Date (initial office visit)

_____ Date Films Checked Out

_____ Legal Guardian (if applicable)