I AUTHORIZE THE FOLLOWING PERSONS TO HAVE ACCESS TO MY RECORDS PER HIPAA

Name	Relationship	Home or Cell Phone	Work Phone
Name	Relationship	Home or Cell Phone	Work Phone
Name	Relationship	Home or Cell Phone	Work Phone

I ____Authorize ____ Do Not Authorize, Midwest Imaging Centers, to leave messages on my home/cell phone regarding appointments, payments and/or billing.

ACKNOWLEDGEMENT OF MEDICAL RECORDS POLICY

Midwest Imaging will provide one original set of images for the patient in the event they are needed for follow up appointments. It is the patient's responsibility to inform Midwest Imaging of any appointment dates/times in which the images would be needed for other doctors and or facilities.

I understand it is my responsibility to maintain the copy of my images for future appointments if I take them with me today. I further understand that if I want/need additional copies of reports and/or images generated through this office there will be a $10.00 medical records charge. Midwest Imaging **requests 24 hour advance notice in order to have images/medical records available for pickup.**

Printed Name **Signature of Patient of Patient Representative**

By patient on day of service ____YES ____NO Verified by Staff _____ Date _____