35 Kennedy Drive
Putnam, CT 06260

THE CENTER
FOR BONE & JOINT CARE
ORTHOPEDIC ASSOCIATES OF WINDHAM COUNTY

5 Founders Street
Willimantic, CT 06226

Authorization for Release of Radiographs/Reports

Name of Patient: _____

Date of Birth: _____

Phone: _____

For Radiology Studies performed before May 2011:

- I hereby assume all legal responsibility for films/reports that I am removing from The Center for Bone & Joint Care.
- I understand that if these films are lost, destroyed, or misplaced, the sole responsibility is mine.
- I understand that The Center for Bone & Joint Care is not obligated to relocate these films if they are not returned to their office.

For Radiology Studies performed after May 2011:

- I understand that images copied for my personal use or for use by my attorney will be subject to a processing fee of $5.00 per cd.
- I understand that images copied for use by another medical provider and/or my insurance carrier will be provided free of charge.

_____ _____

Signature Date

If not signed by the patient, indicate relationship to the patient: _____