Cedar Lake Office
1720-C Medical Park Dr.
Biloxi, MS 39532
Phone: 228-354-0251

THE MRI CENTER
www.TheMRICenterMS.com
Fax: 228-396-3550

East Lake Office
6300-B East Lake Blvd.
Gautier, MS 39565
Phone: 228-447-4MRI (4674)

CONSENT FOR MRI EXAMINATION

Patient Name: _____ DOB: _____

Authorization To Use, Obtain and Disclose Health Information

I have read and understand The MRI Center Notice of Privacy Practices. I authorize The MRI Center to use, obtain and disclose specific health and medical information regarding my treatment for the purposes described to/from my insurance company, my primary care physician, area hospitals and facilities and other health care providers. I acknowledge that I am responsible for providing and updating my insurance, demographic, primary care physician as well as other care providers to The MRI Center.

Consent for Treatment

I hereby give my consent to perform MRI examination(s) as deemed necessary by my physician. **(Should the patient be a minor or legally impaired, a signature of a parent or legal guardian is required before imaging can be started.)**

Irrevocable Assignment of Benefits

I hereby assign to The MRI Center any benefits under any policy or other payor for my MRI examination(s). I hereby authorize this provider to allow my signature of endorsement to checks made payable to provider only and myself for procedures rendered to me by The MRI Center. I fully understand that I am directly and fully responsible to The MRI Center for all charges incurred for MRI examination(s).

Radiological-Surgical Correlation

As part of our ongoing commitment to quality patient care, we conduct regular radiological-surgical correlation. I authorize the release of pertinent surgical reports (if applicable) to The MRI Center for this purpose.

Medical Release & Payment Authorization

I authorize release of any medical information necessary to interpret this study and process this claim. I certify that the foregoing statements are true and correct. I authorize payment of medical benefits to the interpreting physician or supplier for services rendered. I understand that I am fully responsible to the interpreting physician for charges not covered by my insurance.

Financial

I hereby assign, transfer and set over to The MRI Center all my interest to medical reimbursement benefits under my insurance policy. Furthermore, I attest that I have provided accurate and reliable insurance information to The MRI Center. And, regardless of insurance coverage, I acknowledge that I am financially responsible for all services provided.

Permission To Give Medical Information

I hereby authorize the physicians and staff of The MRI Center to give information concerning my health and well being to the person(s) listed below. Including, appointment times, test/lab results, medication, procedures and any information regarding my health.

1._____ _____
(Full Name) (Relationship)

Signature _____ Date _____
(Patient/Parent/Legal Guardian Representative