Account Number: _____

TALLAHASSEE ORTHOPEDIC CLINIC

DISCLAIMER OF LIABILITY FOR MULTIPLE RADIOLOGIC STUDIES

In the event you or your physician provide a disk or other media that contains multiple radiology images or studies, Tallahassee Orthopedic Clinic ("TOC") physicians will only review those images or radiologist reports related to the problem for which you are being treated by a TOC physician. In some cases, your TOC physician will only review the radiologist report for the radiological study performed related to the problem for which you are being treated by the TOC physician and will not review any other images contained on the disk or other media. TOC is not responsible for study results that have not been sent to TOC or brought by the patient.

I (*print patient name*), _____, acknowledge that TOC physicians will not review all radiological images, studies and reports on the computer disk or other media I or my physician provided to TOC, and will only view to the extent deemed medically necessary and appropriate the report issued by the radiologist and those specific images relevant to the treatment to be provided by TOC; and I hereby acknowledge and agree that I, my successors, and my assigns forever release from liability TOC, its Board of Directors, shareholders, agents, employees, independent contractors, and designees ("Released Parties") from any and all claims or demands for personal injury, sickness or death, of any nature whatsoever which may be incurred by the undersigned and/or the minor or incompetent patient that may result in the event a Released Party does not read any or all radiological images, studies or reports on the computer disk or other media I or my physician provided to TOC. To the extent that the radiology report indicates that follow up should be initiated for any condition, injury, or illness that is not associated with the basis for the treatment provided by TOC, it shall be the responsibility of the patient and his or her primary physician to arrange for any needed follow up or treatment.

I certify that I am at least 18 years of age (or if under 18 years of age, that I am joined herein by my parent or legal guardian) and that this release is signed voluntarily, under no duress, and with the full understanding of the terms of this Agreement.

This Agreement contains the full terms of release intended by the parties and may not be changed except in writing signed by both parties to this Agreement.

_____ _____

Patient Printed Name **Date of Birth**

_____ _____

Patient Signature or Signature of Legal Guardian **Date of Signature**
(*If patient is under the age of 18 or incompetent*)