Brookside Radiology Consultants, Inc.
P.O. Box 349
Buzzards Bay, MA 02532
Phone: 508-743-5691
Fax: 774-302-4713

X-Ray Assignment Agreement and Consent

I understand that **QUINTESSENTIAL CHIROPRACTIC** is submitting my X-Rays for radiological interpretation and report by John R. Henry, DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I give my consent to Brookside Radiology Consultants, Inc. for use and disclosure of my Protected Health Information for the purpose of providing treatment to me and for general healthcare operations purposes.

I acknowledge that I have reviewed, with my doctor, and understand and agree to the Notice of Privacy Practices of BRC, Inc.

_____ _____
Print Name Patient Signature

_____ _____
Date Parent/Guardian Signature

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____ Sex: M F

To be completed by office staff:

Referring Doctor: _____ Date of Films: _____

Clinical Concern: _____

Comments: _____

X-Ray Studies Submitted: _____