HALŌ
BREAST CARE CENTER

3D Mammography | Breast Ultrasound | Breast Biopsy
General and Vascular Ultrasound | DEXA Bone Density
Lara Bussey, DO | Craig Letner, MD | Mauricio Schrader, MD

Designation and Consent for Release of Medical Records

I understand that HALO Breast Care Center will not condition treatment or payment on my providing or refusing to provide this authorization.

PATIENT NAME:_____DOB: _____ MRN:_____

I hereby authorize HALO Breast Care Center (including Northstate Imaging) to disclose, allow requesting and/or retrieval ONLY of medical imaging media & reports on my behalf; to the following designated persons below. This is NOT authorization or consent to treatment.

_____
Name
_____
Phone Number Relationship

_____
Name
_____
Phone Number Relationship

_____
Name
_____
Phone Number Relationship

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

X_____ _____
Signature **Date**