HALŌ
BREAST CARE CENTER

3D Mammography | Breast Ultrasound | Breast Biopsy
General and Vascular Ultrasound | DEXA Bone Density
Patricia Hadley, MD | Craig Letner, MD | Mauricio Schrader, MD

Authorization and Request 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 (formerly North State Radiology) to disclose to:

_____

Name Phone

_____

Address

_____

City State Zip

Medical Information that you are requesting:

- ☐ Medical Imaging Reports Only
- ☐ Patient Personal Records – $10.00 charge for CD and report

Delivery:

- ☐ In Person Pick Up
- ☐ Mail to

Records pertaining to: _____

Patient's identity must be verified prior to the release of records or to authorized designated personnel.

REQUESTS MAY TAKE UP TO 3 BUSINESS DAYS TO PROCESS

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**

Staff Use Only:

_____ _____ _____

Received By: (Name) Completed By: (Name) Date Entered into VSDM: