3D Mammography | Breast Ultrasound | Breast Biopsy
General and Vascular Ultrasound | DEXA Bone Density

Lara Bussey, DO | 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 Chico Breast Care Center / North State Imaging) to disclose to:

____
Name

____
Address

____
City State Zip

Please check appropriate box for the Medical Information that you are requesting:

☐ Medical Imaging Reports

☐ Medical Images on a CD and/or report (only with HAND CARRY on order or VERBAL request from provider to HALO Breast Care Center).

☐ Patient personal records – there is a $10.00 charge for CD and report.

Records pertaining to: ____

Employee signature below confirms that the patient's ID was verified prior to the release of records:

Employee signature: ____

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**

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