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

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:** _____

I hereby authorize:

_____
NAME OF DISCLOSING PARTY

_____
ADDRESS CITY STATE ZIP

To disclose to:

☐ HALO Breast Care Center FAX: (530) 898-0533 1720 Esplanade Chico, CA 95926

Records and information pertaining to:

_____
PATIENT NAME (print) **DATE OF BIRTH**

Specify the records to be disclosed:_____

_____

PLEASE FAX OR MAIL RECORDS WITHIN 24-48 HOURS FOR EFFICIENCY OF CARE

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**