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

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

_____

Address City State Zip

TO DISCLOSE TO:

HALO Breast Care Center
1720 Esplanade, Chico, CA 95926
(530) 898-0502 Phone | (530) 898-0533 FAX

RECORDS & INFORMATION PERTAINING TO:

_____

_____

We are a Nuance PowerShare Hub and if your facility participates in the PowerShare program, you may send or share the requested images to us via that program. Please fax the report(s) if not included in the requested studies.

PLEASE FAX, SHARE 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**