HALŌ

3D Mammography | Breast Ultrasound | Breast Biopsy
General and Vascular Ultrasound | DEXA Bone Density
MRI Imaging | CT Imaging | PET-CT Imaging

3RD PARTY DESIGNATION AND CONSENT

NAME: _____ DOB: _____ MR#: _____

I hereby authorize HALO Breast Care Center (formerly North State Radiology) 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

_____ _____
Relationship Phone Number

_____
Name

_____ _____
Relationship Phone Number

_____
Name

_____ _____
Relationship Phone Number

Identity must be verified prior to release of records to authorized designated personnel.

This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of signature. This authorization is 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 of this authorization. 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 HALO Breast Care Center will not condition treatment or payment on refusing to provide this authorization. I understand that I have the right to receive a copy of this authorization.

X_____ _____
Signature Date

OFFICE USE ONLY

☐ WORKMAN'S COMP. ☐ PAID FOR ☐ SCANNED-IN ☐ COMPLETED: