HALŌ

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

PRIOR IMAGING & RECORDS REQUEST

NAME: _____ DOB: _____

I hereby authorize:

_____
FACILITY NAME PHONE NUMBER

_____
ADDRESS CITY STATE ZIP

TO DISCLOSE TO: **HALO DIAGNOSTICS & BREAST CARE CENTER**
1720 ESPLANADE, CHICO, CA 95926
(530) 898-0532 Phone | (530) 879-4661 FAX

RECORDS & IMAGING PERTAINING TO:

_____

_____

_____

Per HIPAA Regulation 164.512, a signed medical release is not required for continuation of care.

We are a Nuance PowerShare Hub. You may upload the requested imaging using the link below:

https://widgets.nuancepowershare.com/easyupload/halobreastcare

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.

1ST REQUEST: _____

2ND REQUEST: _____

3RD REQUEST: _____

X_____ _____
Signature Date