HALŌ

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

MEDICAL RECORDS RELEASE

NAME: _____ DOB: _____ MR#: _____

I hereby authorize HALO Breast Care Center to disclose to:

_____
NAME PHONE

_____
ADDRESS

_____
CITY STATE ZIP

Patient Personal Records Requested:

- ☐ Medical Imaging Reports ONLY
- ☐ Medical Imaging Reports & CD - **$10 Charge**

Delivery – Patient ONLY:

- ☐ In Person Pick Up
- ☐ Patient Portal Secure Email
  (Only to email associated with Patient Portal)

External Medical Facility / Out of State:

- ☐ Medical Imaging Reports ONLY
- ☐ Medical Imaging Reports & CD - **$10 Charge**

Delivery – External ONLY:

- ☐ Fax to Medical Facility / Out of State
- ☐ Mail to Medical Facility / Out of State

Pertaining to: _____
Patient's Identity must be verified prior to release of records to authorized designated personnel.

MAILING OF PERSONAL RECORDS NOT AVAILABLE

REQUEST MAY TAKE UP TO 5 BUSINESS DAYS TO PROCESS

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: