CharlotteRadiology

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including HIPAA (Health Insurance Portability and Accountability Act). I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Patient Name____ Social Security #______________________________

Previous Name(s) (if different)_________________________________ Date of Birth_________________________________

Daytime Phone #________________________ Mobile #___________________________

Persons/Organizations providing the information:____

Address____
Street City State Zip Code

Phone #_______________________ Fax #_____________________

We are requesting **All Previous Mammography Studies/Breast Related Imaging and Reports on the above patient** to be used for comparison. **Please send a CD in Dicom format or the original analog films with reports.** This information may be disclosed to and used by the following organization:

Charlotte Radiology
Attn: Medical Records
8514 McAlpine Park Dr, Ste 100
Charlotte, NC 28211
Phone: (704)362-7060 Fax: (704) 362-7036

Please call if Patient's films are not available or no record for this patient.

I understand I have the right to revoke this authorization in writing at any time by sending written notification to Privacy Officer at 700 E Morehead St, Ste 300, Charlotte, NC 28202. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in the HIPAA regulations. I understand any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules. I understand that any photocopy of this document will be considered as valid as an original. If I have questions about disclosure of my health information, I can contact the Privacy Officer at the above named facility.

______________________________________ ______________________________________
Signature of Patient or Legal Representative Date

______________________________________ ______________________________________
Legal Representative, Relationship to Patient Signature of Witness

For Staff Use Only: MRN________________________________