

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND/OR REQUEST FOR COPY OF MEDICAL IMAGES

TRANSFER RECORDS FROM: <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p align="center"><i>Charleston Breast Center</i> 1930 Charlie Hall Blvd Charleston, SC 29414 843.556.0116(office) 843.556.3844 (fax)</p> </div>	TO: Patient directly <input type="checkbox"/> Given to patient on: _____ By: _____ <input type="checkbox"/> Patient to picked up on: _____ name _____ Hospital to pick up on: _____ Other:
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PATIENT INFORMATION:	REASON MUST BE COMPLETED:										
Patient name: _____	<input type="checkbox"/> MRI at <u>name of facility</u> <input type="checkbox"/> Transferring care to: <u>name of facility</u> because: <ul style="list-style-type: none"> <input type="radio"/> Moved <input type="radio"/> Unable to get appointment at CBC <input type="radio"/> My preference <input type="radio"/> Referring provider request <input type="radio"/> Other: _____ <input type="checkbox"/> Needed for surgery/radiation/chemotherapy <input type="checkbox"/> Other:										
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%; padding: 2px;">MRN:</td> <td style="padding: 2px;">DOB:</td> </tr> </table>		MRN:	DOB:								
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Referring physician: _____											
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I hereby authorize the Charleston Breast Center (CBC) to release the medical records that I requested above. I understand the CBC may require reasonable verification of my identity prior to permitting inspection or copying of my records and that any fees or charges related to the handling of these records is expected at the time of this request. I also acknowledge that a minimum of 48 hours is required to process this request.

This authorization shall remain in effect for 1 year. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Charleston Breast Center. Information used or disclosed by this authorization may be subject to redisclosure by the recipient and will no longer be protected by the CBC. **I also acknowledge and fully release the Charleston Breast Center from all and any harm from unauthorized/unintended use of these films, images, medical information and medical reports.** I understand that these films, records and/or discs do not need to be returned to the Charleston Breast Center.

I have requested a copy of my medical records and reports. I understand that the first copy is provided to me at no cost, unless postage and handling is required. Any subsequent copies of the films and records will be charged to reflect the cost of providing these records along with any additional postage and handling charges.

<input type="checkbox"/> Mail records to:	
<input type="checkbox"/> I request to receive follow up care at the CBC.	<input type="checkbox"/> I request to be dropped from recall and will <u>NOT receive</u> follow up care at the CBC
Signature: _____	Date: _____
Print: _____	_____

OFFICE USE ONLY:

Date of this request/initials	Date records needed/initials
Date completed/initials	Comments/fees collected:

2008-11