

**AUTHORIZATION FOR RELEASE OF IMAGING INFORMATION**

CHARLESTON BREAST CENTER  
1930 Charlie Hall Blvd. Charleston, SC 29414  
(843) 556-0116

\_\_\_\_\_  
Print patient's full name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Street address

\_\_\_\_\_  
Social security number

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone

I \_\_\_\_\_, do hereby authorize \_\_\_\_\_  
(Patient's Name) (Facility, Provider)

to release records.

\_\_\_\_ I do \_\_\_\_\_ I do NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessment, and treatment for alcohol and or drug abuse.

INFORMATION RELEASE TO:

**Charleston Breast Center  
1930 Charlie Hall Blvd.  
Charleston, SC 29414**

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. Understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving the information.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date