BayCare
Imaging Services

AUTHORIZATION FOR USE *and* DISCLOSURE OF PROTECTED HEALTH INFORMATION – IMAGING SERVICES

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, & Zip: _____

Phone Number: _____ Email: _____

Release To/From *(e.g. individual, physician, or facility/organization)*:

Name of Individual/Physician/Facility: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

Purpose of Disclosure:

☐ Continuing Care

☐ Legal _____

☐ Personal Use

☐ Other *(specify)*:
_____

Records Requested
(List exam type and date performed)

_____

_____

_____

Record Format Requested:

☐ Electronic *(sent via the portal/cloud)*

☐ CD *(sent to address listed above)*

☐ Reports

☐ All previous Breast Imaging including Mammogram and Ultrasound

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THIS SECTION IS UTILIZED BY PHYSICIANS ONLY.

I verify that the patient whose records are being requested is scheduled for treatment/procedures at my office or otherwise under my care. These records have been requested to assist in the continuity of patient care.

Physician Name (Print): _____

Physician Address: _____

Physician Signature: _____ Date/Time: _____

I understand if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations. I understand I need not sign this authorization to ensure treatment. This authorization remains valid for six months from the date signed below.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I acknowledge that I have read the above and authorize the disclosure of protected health information as stated:

Signature: _____ Date/Time: _____

Patient or Authorized Person*:*

☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney ☐ Written Authorization ☐ Patient Email

Requestor/Witness Information:

Name of Authorized Representative (Print): _____ ☐ Photo ID Checked