Patient Name: X ______________________

Date of Birth: X ______________________

AUTHRELSE

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

Form Origination Date: 4/2017

Version: 2 Version Date: 07/18

Records Obtained From:	**Organization:** X **Address** ______ **City:** X **State** X **Zip Code:** ______ **Day Phone Number:** ______ **Fax Number** ______
Records to be Sent to:	Please Fax or Mail/Email to: [X] *Mail* [ ] *Fax* [ ] ***Email / Other*** ______ MUSC Clinic/Dept. MUSC BREAST IMAGING CENTER Attn: ______ Address 1600 MIDTOWN AVE City MT. PLEASANT State SC Zip Code 29464 Fax Number 843-876-8250 Phone Number 843-876-8127
Purpose of Release:	[X] Continuing Care [ ] Referral * Patient Authorization is not required for continued care or referral purposes.
Treatment Date(s):	[ ] 2 years prior from last date seen [ ] All Treatment Dates Dates Other: ______
Information to be Released:	[ ] Entire Medical Record [ ] Abstract Information [X] Radiology Images / DVD (**NOT** Included in Entire Record) [ ] Clinic/Office visit notes [X] Other: MAMMOGRAMS

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from the date below. I understand that only records available as of this date will be provided in response to this request. Should I need additional records in the future; a new request will be required.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

X ______________________ ______________________

Printed Name of Patient or Legal Guardian / Representative Date

X ______________________

Signature of Patient or Legal Guardian/Representative

______________________ ______________________

Relationship to Patient, if signed by Legal Guardian Witness Signature

Document(s) of patient representative's authority must be attached if patient is not signing.