AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This form must be completed in full in order for this form to be valid.

Patient Name _____ Date of Birth _____
Address _____
Last 4 Digits of Social Security Number __ __ __ __ Daytime Phone _____

I AUTHORIZE _____ TO RELEASE TO:
(Facility Name)

NAME _____
ADDRESS _____
PHONE NUMBER _____

THE FOLLOWING INFORMATION FROM THE ABOVE PATIENT'S RECORD:

___x____ (Original) Breast imaging **films/cds** and **reports** including breast ultrasounds, breast biopsy procedures and corresponding reports for comparison purposes:

CD of Digital Images or ultrasound done on: _____

Original x-rays done on: _____

_____

Outside films done on: _____

Ultrasound hard copy done on: _____

_____
Signature of patient or authorized legal representative Date

(D.I.S.C. Office Use Only)

Films given to: _____ Date: _____ by: _____

Films sent to: _____ Date: _____ by: _____

NOTICE TO PATIENT

I understand that this consent is valid 90 days from the date of signature. I understand that I may revoke this consent at any time by giving written notice to D.I.S.C., P.C. to the extent that D.I.S.C., P.C., which is to make the disclosure, has already acted in reliance on it. This authorization will automatically expire when the information requested has been released if I have given no prior notice as stated above. I understand that these may be original films and that once they are released I am responsible for their whereabouts or return and that there are no longer any films (or copies) from the above exams as part of the permanent record. Any fees involved in the transfer of records are the patient responsibility.

Diagnostic Imaging Specialists of Chicago, P.C.
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