Please release information to:

THE BREAST CENTER
@ Portsmouth Regional Imaging Center
155 BORTHWICK AVENUE, SUITE 101 WEST
Portsmouth, NH 03801
Phone: (603) 433-5191
Fax: (603) 957-5479

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION
Prior Breast Imaging Studies at your Facility CD Accepted/Preferred

I hereby authorize
(Name of facility) _____

Address: _____

Phone #: _____ **Fax #:** _____

Release my medical record information (imaging and reports) to Portsmouth Regional Breast Center

Patient Name: _____

Patient Date of Birth: _____ **Patient's prior Name:** _____

Phone #: _____

I UNDERSTAND THAT:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the unencrypted format of my protected health information as stated

_____ _____ _____
Date **Signature of Patient/Parent/Patient Representative** **Relationship to Patient**

ROI