1960 DIGITAL IMAGING
BREAST CARE CENTER

837 Cypress Creek Parkway, Suite 108
Houston, TX 77090

I hereby authorize the release of information from the medical record of:

Patient Name: ____ Date of Birth: _________________________________

Social Security # ______________________________________ (optional) Daytime Phone # _____________________________

Information Released

FROM: ____

____

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Please Release the Following:

__**X**__ Mammogram Films __**X**__ Mammogram and ultrasound reports

__**X**__ Ultrasound Films

__X__ Other Diagnostic Reports (biopsy, MRI, etc.) ____

_____ Other (Specify) ____

Purpose or Need for Disclosure:

__**X**__ Continued Patient Care ****THIS IS A TEMPORARY TRANSFER. ****

****FILMS WILL BE RETURNED. ****

Other (specify) ____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

____ ____
Signature of Patient or Legal Representative Date

____ ____
Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASE DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that ***only a physician can interpret***. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold 1960 Family Practice liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

____ ____
Signature of Patient or Legal Representative Date

____ ____
Relationship to Patient Witness