Patient ID: _____

AUTHORIZATION FOR PATIENT HEALTH INFORMATION

I hereby authorize and request the disclosure of my individually identifiable health information as described below.

PATIENT NAME: _____ **DATE OF BIRTH**: _____

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: _____

I request that _____release copies of my medical records including mammogram films and/or images on CD, and reports to the Knoxville Comprehensive Breast Center (KCBC).

Facility authorized to **disclose** the information:

Name: _____

Address: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE RELEASED:

Dates of service/exam type: _____

Type of Information (check all that apply): ☐ Report(s) ☐ Images on CD ☐ Films

The patient or the patient's representative must read and initial the following statements:

- I understand that this authorization will expire 6 months for the date of the request. Initials: _____
- I understand that I may revoke this authorization at any time by notifying KCBC in writing, but if I do revoke it, the revocation will not have any effect on any actions KCBC took before receiving the revocation. Initials: _____

_____ _____

Signature of Patient or the patient's representative **Date**

Printed name of patient or representative: _____

If representative, relationship to the patient: _____

_____ _____

Authorizing Signature (KCBC Employee) Date

For KCBC office use:

☐ Requested records as requested on _____
Date

Records received from: _____ Date: _____