UNIFIED
WOMEN'S HEALTHCARE℠

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
Breast Images and Reports

Patient Name:_____Date of Birth:_____Prior Last Name: _____

Patient Address:

_____

I hereby authorize (physician's name):_____

To disclose breast images and reports for the following date range _____ to:

Name: **Midwest Center for Women's Healthcare**

Address: **350 S. Northwest Hwy, Ste 120**

City: **Park Ridge** State: **IL** Zip Code: **60068**

Requested method of disclosure:
__Mail to above patient address___Hand delivered to patient ____Mail to above provider___Electronically Transferer

I understand and agree to the following:

- This information will be used or disclosed for continuum of care.
- The requestor of this information understands that the information contained on this disc is not secure.
- The physician has offered to provide this PHI in a secure manner, but the patient has requested PHI not be secured by encryption.
- Once the PHI is mailed or picked up, the requestor is responsible for the security of the PHI and does not hold physician responsible for any disclosure.
- This authorization shall remain valid unless revoked and will expire 1 year after signing. This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee the recipient will not redisclose my health information to a third party not subject to applicable federal and state law governing the use and disclosure of my health information.
- I understand that signing this authorization is voluntary and will not condition my treatment, payment, enrollment or eligibility for benefits.

_____ _____
Signature of Patient or Substitute Decision Maker Date

_____ _____
If Substitute Decision Maker, state relationship If Substitute Decision Maker, state reason