Community Imaging at Clear Lake Breast Center

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Phone (346) 326-2490 | Fax (844) 656-3680
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I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Address _____ City, State, Zip _____

Daytime Phone # _____

Information Released

FROM: _____

_____

_____

Please Release the Following:

☐ Mammogram Films ☐ Mammogram Report

☐ Ultrasound Films ☐ Ultrasound Report

☐ Other Diagnostic Reports (biopsy, MRI, etc.) _____

☐ Other (Specify) _____

Purpose or Need for Disclosure:

☐ Continued Patient Care

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 Community Imaging at Clear Lake 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