Community Imaging at Clear Lake Breast Center will be temporarily closing as of December 31, 2022 until further notice.

If you would like your medical records transferred to another provider, please complete the "Consent to Release Confidential Medical Information" on the next page and return to our office.

During the time the office is temporarily closed, your medical records will continue to be stored by Community Imaging of Clear Lake Breast Center. During the temporary closure, medical record requests can be sent by email, fax or mail.

Email: Imaging@MedicalCareofTexas.com

Fax: (844)656-3680

Mail: Community Imaging
Attention: Medical Records
2306 Rayford Rd
Spring, Texas 77386

Requests will be filled as per time limitations dictated by state law retention requirements.

We apologize for any inconvenience this temporary closure may have caused.

We do appreciate your trust in Community Imaging for your health care needs.

Sincerely,

Community Imaging at Clear Lake
Breast Center

CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME: ____ DOB:______________________

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

DAYTIME PHONE: ____

I AUTHORIZE MEDICAL IMAGING ASSOCIATES OF AMERICA, PA, DBA COMMUNITY IMAGING AT CLEARLAKE TO RELEASE THE FOLLOWING SPECIFIC CONFIDENTIAL INFORMATION:

☐ MAMMOGRAM FILMS ☐ MAMMOGRAM REPORT

☐ ULTRASOUND FILMS ☐ ULTRASOUND REPORT

☐ OTHER (BIOPSY REPORT, ETC) (SPECIFY)____

TO THE FOLLOWING INDIVIDUAL/ORGANIZATION:

____
(NAME OR POSITION OF INDIVIDUAL OR ORGANIZATION)

____
(STREET ADDRESS) (CITY) (STATE) (ZIP)

THE INFORMATION RELEASED MAY BE USED BY THE INDIVIDUAL, OR THE ORGANIZATION REPRESENTED BY THE INDIVIDUAL FOR THE FOLLOWING PURPOSE(S):

☐ CONTINUED PATIENT CARE ☐ OTHER (SPECIFY) ______________________________________

I UNDERSTAND THAT 1) THE INFORMATION RELEASED IS FOR THE SPECIFIC PURPOSE STATED ABOVE AND 2) ANY OTHER USE OF THIS INFORMATION WITHOUT THE WRITTEN CONSENT OF THE PATIENT IS PROHIBITED AND 3) I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THE ACTION HAS ALREADY BEEN TAKEN IN RELIANCE ON IT AND 4) THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE SIGNATURE DATE UNLESS SPECIFIED.

ALTERNATE EXPIRATION DATE: ____

DISCLAIMER: IF INFORMATION IS BEING RELEASED 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 INTERPRETATION OF MY MEDICAL RECORD TO PREVENT MY MISUNDERSTANDING OF THE INFORMATION CONTAINED IN THESE RECORDS. 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) (SIGNATURE DATE)

____
(RELATIONSHIP TO PATIENT / WITNESS)

THIS CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION MUST BE COMPLETED IN FULL AND SIGNED – ALL BLANKS ON THE FORM MUST BE FILLED IN BEFORE THE INFORMATION IS RELEASED. COMPLETED FORMS CAN BE EMAILED TO IMAGING@MEDICALCAREOFTEXAS.COM OR FAXED TO (844)656-3680 OR MAILED TO COMMUNITY IMAGING, ATTENTION: MEDICAL RECORDS, 2306 RAYFORD RD, SPRING, TEXAS 77386.