PATIENT AUTHORIZATION FOR USE BY BREAST CARE SPECIALISTS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing, I authorize BREAST CARE SPECIALISTS, LLC to use and/or disclose certain protected health information (PHI) about me to (please list your referring physician(s) and or any other physician that you would like to receive a copy of your medical record (PHI) generated as part of your establishment as a patient of BREAST CARE SPECIALISTS, LLC. ***Failure to authorize release of PHI may prevent the exchange of vital information associated with care delivery.***

Name Address Phone

_____

_____

_____

This authorization permits BREAST CARE SPECIALISTS, LLC to use and/or disclose the following individually identifiable health information about me (please check all that apply – if unsure, please check all boxes)

- ☐ Office Notes (office visit MD notations)
- ☐ Ultrasound Reports
- ☐ Other _____
- ☐ Mammogram Reports
- ☐ Pathology Reports

The information will be used or disclosed for the following purpose: (please check)

- ☐ At the request of the patient
- ☐ Other _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will automatically renew. The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, only in some cases a fee for the copying of the information.

- ✓ I hereby give my consent for BREAST CARE SPECIALISTS, LLC *to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations* (TPO). (The Notice of Privacy Practices provided by BREAST CARE SPECIALISTS, LLC describes such uses and disclosures more completely.) Without consent, PHI will not be disclosed and may delay patient-requested activity.
- ✓ I have the right to review the Notice of Privacy Practices prior to signing this consent. BREAST CARE SPECIALISTS, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, 975 Johnson Ferry Rd NE, Suite 500, Atlanta, GA 30342.
- ✓ With this consent, BREAST CARE SPECIALISTS, LLC *may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.*
- ✓ With this consent, BREAST CARE SPECIALISTS, LLC *may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."*

By signing this form, I am consenting to allow BREAST CARE SPECIALISTS, LLC to use and disclose my PHI to carry out TPO. I do not have to sign this authorization in order to receive treatment from BREAST CARE SPECIALISTS, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Breast Care Specialists, LLC

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

Revised 01/08