

**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 the physicians listed below 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	Fax
Referring Physician: _____			
Primary Care (Internist, Family Doctor): _____			
OB/GYN: _____			
Other: _____			

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)

<input type="checkbox"/> Office Notes (office visit MD notations)	<input type="checkbox"/> Mammogram Reports
<input type="checkbox"/> Ultrasound Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Other: _____	

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, 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	
_____	_____	

MAGNETIC RESONANCE (MR) PATIENT SCREENING FORM

WARNING: THE MRI MAGNET IS ALWAYS ON! If exposed to the magnetic field, certain implants, medical devices, or objects in or on your body may become hazardous to you, may malfunction, or may interfere with the MRI procedure. DO NOT ENTER the MRI area if you have any concern regarding an implant, device, or object.

Name _____ DOB ____/____/____ Age__ Weight _____ lbs.
Last name First name Middle Initial

Did you take anxiety medication prescribed by BCS ? **Y**____ **N**____

If yes, who will be driving you home? _____

List any **drug** allergies and type of reaction: _____

Are you experiencing any new problems with your breasts? _____

Do you have breast implants? **Y**____ **N**____

If , circle type: **Right:** silicone saline **Left:** silicone saline

First date of last menstrual period: ____/____/____ or Post/Peri-Menopausal **Y**____ **N**____

Have you had a hysterectomy **Y**____ **N**____

Are you or could you be pregnant? **Y**____ **N**____

Are you currently breastfeeding? **Y**____ **N**____

Do you have any kidney (renal) or liver (hepatic) problems? **Y**____ **N**____

If Yes, please explain: _____

Do you have high blood pressure? **Y**____ **N**____

Do you have Diabetes? **Y**____ **N**____

Have you had an imaging exam with **any type of contrast dye (gadolinium or iodinated contrast)?** Yes____ No____

Have you ever had a reaction to **any type of contrast dye (gadolinium or iodinated contrast)?** Yes____ No____

If yes, please describe: _____

Have you had an injury to your **eye** involving a metallic object or fragment (metallic slivers, shavings, foreign body, etc.)?

Yes __ No__ If yes, please indicate the type of surgery: _____

Have you ever been injured by a metallic object or foreign body (BB, bullet, shrapnel, etc.)?

Yes__ No __ If yes, please indicate the type of surgery: _____

Are you taking any type of oral contraceptives, hormone replacements, or having fertility treatments?

Yes__ No__ If yes, please describe: _____

Have you had prior surgery or an operation of any kind **in the last 8 weeks?**

Yes __ No__ If yes, please indicate the type of surgery: _____

Please circle Yes or No if you have the following:

Aneurysm clip	Yes / No	Tissue expander/implant spacer	Yes / No
Cardiac pacemaker	Yes / No	Breast biopsy clip	Yes / No
Cochlear implant or hearing aids	Yes / No	Neurostimulator device	Yes / No
Implanted cardiac defibrillator	Yes / No	Medication patch	Yes / No
Implanted epicardial pacemaker leads	Yes / No	Tattoo/permanent makeup	Yes / No
Prosthetic heart valve or replacement	Yes / No	Body piercing	Yes / No
Implanted insulin or chemotherapy pump	Yes / No	Prosthesis (eye, limb)	Yes / No
Electronic or magnetically activated implant /device	Yes / No	IUD, pessary, diaphragm	Yes / No
Vascular access port or catheter	Yes / No	Orthopedic hardware	Yes / No
Shunt (spinal, ventricular)	Yes / No	Harrington rods	Yes / No
Metallic stent, filter, or coil	Yes / No	Dentures/removable dental work	Yes / No
Magnetic Cosmetics (IE. Nailpolish,lashes,eyeliner)	Yes / No	Glucose Monitor	Yes / No
Wig/Weave/Extensions	Yes / No	Moisture Wicking (Fabrics /Compression Underwear)	Yes / No
Period Panties/Underwear	Yes / No		

Are you:		Do you have:	
Taking blood thinners or aspirin?	Yes / No	Seizure disorder	Yes / No
Taking Tamoxifen/Arimidex/Femara?	Yes / No	Involuntary movement disorder	Yes / No
Claustrophobic?	Yes / No	Asthma	Yes / No

Important Instructions:

All patients must be in BCS provided scrub pants & gown. All clothing (other than panties) including but not limited to hosiery, leggings, compression garments must be removed & cannot be worn under scrubs/gown. Before entering MRI environment, you MUST remove all metallic objects including jewelry, hairpins/bobby pins and piercings.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure.

Signature of patient or person completing form: _____ Date: _____

Relationship to patient: _____ **Medication Guide distributed to patient:** _____

Witness/Technologist: _____ Reviewed & Approved by: _____ M.D. or R.T.(R)(MR) Date: _____

What size scrub pants do you wear? Small___ Medium___ Large___ X-Large___ 2X-Large___ 3X-Large___

For office use: MR# _____ Lot# _____ Study ID _____ Ordering M.D. _____