



Tampa Bay Breast Care Specialists, LLC

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Phone Number: _____ SS#: _____

Contact Person(if other than patient): _____ Phone: _____

I authorize Tampa Bay Breast Care Specialists to release my medical records (including medical information related to the diagnosis or treatment of HIV testing, drug and alcohol, or a psychiatric condition) as specified below:

Visit Type

Emergency Visits: Service Date(s): _____

Inpatient Hospitalization: Admission/Discharge Dates: _____

Outpatient Service: Service Date(s): _____

All of the Above: Inclusive of all dates.

Medical Information

Complete Medical Record

Xray

Pathology Reports

Demographic/Visit Hx

Lab

Hx & Physical Exam

Operative Reports

Discharge Reports

EKG & Radiology Reports

Consultation Reports

Other: _____

REASON FOR REQUEST: _____

Delivery Mode

Patient/Designee to Hand-Carry. Please notify patient/contact at above number when records are available for pick-up.

May we leave a message to notify you that records are ready? Yes No

Medical Records Picked Up On: _____ Please Initial: _____

Mail copies to the following individual/organizations:

Name: _____

Street Address: _____

City, State and Zip Code: _____

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services department. I understand revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year.

Copies to the patient will be at no charge the first time. Additional copies to the patient will be assessed a charge. There will be a charge for copies being sent to attorneys, insurance agencies or other companies other than a medical facility for treatment.

Signature: _____

Date: _____