# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security: _____

I request and authorize _____ to release protected healthcare information of the patient named above to:

TOPS Comprehensive Breast Center
17030 Red Oak Dr.
Houston, TX 77090
P:(281)580-6171 F:(281)754-4220

This request and authorization applies to the following: Circle all that apply:

Mammogram Images and reports Dates of Service: _____
Ultrasound Images and reports
Pathology Reports
Bone Density Reports
MRI Images and reports
Other: Please specify _____

The protected health information is being used or disclosed for the following purpose:

☐ **Per Patient request for comparison**

This authorization shall be in force and effective until:

☐ **Permanently Transferred** Or until **Date: _____**

I understand that, as set forth in the Provider's Privacy Notice, I have the right to revoke this authorization at any time by sending written notification to the above address or fax number.

**Patient Signature: _____ Date Signed: _____**

**Note to patient:** For screening mammograms, if your comparison mammograms do not arrive in 7 business days then your mammogram will be read at that time without comparison.

Initial _____