TOPS Comprehensive Breast Center

Use and Disclosure Release Form

I authorize TOPS Comprehensive Breast Center to use and disclose the following protected health information:

Select all that apply: **Date(s) of Service:**

- ☐ Mammogram Images and Reports
- ☐ Ultrasound Images and Reports
- ☐ MRI Images and Reports
- ☐ Bone Density Reports
- ☐ Authorize Verbal Communication
- ☐ Back to school or work release

Release of medical records to be:

☐ Picked up at TOPS Breast Center ☐ Red Oak ☐ Kingwood ☐ Woodlands ☐ Willowbrook

☐ Mailed to facility

The protected information may be disclosed to (name of person or facility) If records are to be mailed please provide name and address to be mailed.

Purpose of disclosure:

☐ Per Patient's request

☐ Other: _____

This authorization shall be in force and effect until:

☐ Permanently

☐ Date _____

I understand that I have the right to revoke this authorization at any time by sending written notification to:

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

I understand that a revocation is not effective to the extent that the provider has taken action or relied on the authorization that is being revoked.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that the provider will not condition my treatment on weather I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

_____
Personal Representatives Signature