Breast Imaging Specialists

# Use and Disclosure of Health Information Form

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**Dipa H. Patel, MD**

Softer mammogram™ PROVIDER

Name: _____ Date of Birth: _____

Last four of SS#: _____

I hereby authorize Breast Imaging Specialists, Inc. to obtain prior mammogram films, breast ultrasounds and medical reports for permanent release from: _____

I understand that as part of my healthcare, Breast Imaging Specialists, Inc originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communications among the healthcare professionals who contribute to my care.
- A source for billing and payment by third party payers.

I authorize the release of my present and prior medical records pertaining to mammograms, breast ultrasound, breast biopsy and lab results to Breast Imaging Specialists, Inc. I also authorize Breast Imaging Specialists, Inc to release all present and prior medical records to other physicians, specialists or healthcare providers involved in my healthcare, and to release my present and prior medical records to my insurance company or companies to facilitate payment. I authorize Breast Imaging Specialists, Inc to act as my representative to enable access for the patient portal of the EHR system.

I authorize Breast Imaging Specialists, Inc to use my de-identified x-ray images and information for educational and research purposes. I understand that separate signed consent forms would be required by the FDA for research projects that meet specific detailed criteria to ensure the privacy of my PHI, as established by the HIPAA Privacy rule.

I authorize payment of medical benefits to Breast Imaging Specialists, Inc. I understand that I am fully responsible for reimbursing Breast Imaging Specialists, Inc for financial charges that are not covered by my insurance. I understand that tomosynthesis and 3D breast ultrasound may not be covered by my insurance plan and I have the option to pay out of pocket for these studies. Depending upon my insurance carrier, if I need to have additional imaging or non screening examinations, these tests may be applied to my deductible and coinsurance and I am financially responsible for these payments.

I may be charged a no show fee if I cancel my scheduled appointment within 24 hours.

I acknowledge that a copy of Breast Imaging Specialists, Inc's Notice of Privacy Procedures is available at the reception desk.

Patient Signature: _____ Date: _____