COMPREHENSIVE BREAST AND SURGICAL CENTER

M. Lisa Attebery, DO, FACOS | *Breast Surgical Oncologist & General Surgeon*

OUTSIDE RECORD RELEASE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____ **Phone**_____

	Records to be released from:	**Records to be released to:**
Name		Comprehensive Breast & Surgical Center
Address		34434 King Street Row, Suite 2
		Lewes, Delaware 19958
Telephone		302-444-0194
Fax		**302-200-9131**

Please FAX the following information (please circle):

Entire chart Last office visit Genetic testing Specific Encounters: _____

Last EKG, Stress test, echo All labs from last ____ years All imaging from last ____ years

Mammograms, Ultrasound and/or MRI of breast, PAP from last ____ years

I understand my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released unless specifically excluded. My initials below indicate records EXCLUDED from this authorization. The following protected information is NOT authorized for released:

____ Drug/alcohol diagnosis/abuse/treatment _____ Sexually transmitted disease

____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment) and I may revoke this authorization in writing at any time except to the extent that action has been taken in regard to this authorization. I understand the information authorized for disclosure (except drug and alcohol treatment records) may be subject to re-disclosure by the recipient listed above, at which time it may no longer be protected under Federal HIPAA Privacy Rules.

Signature of Patient (or Guarantor, if applicable): _____ **Date:** _____

Printed Name of Patient: _____

Signature of Witness (required if patient unable to sign) _____