breastlink of NEW YORK

Authorization of Release of Breastlink Medical Records

I, _____ hereby authorize, Breastlink Medical Group, to release medical records and information pertaining to chart documents:

Patient's Name: _____ Date of Birth: _____

Provider Name: _____

Specific date of Service: _____ Entire Chart: Yes [ ] No [ ]

And/or specific records:

_____

If records are not to be picked up at the Breastlink office, records are to be sent to:
Name: _____ Phone #: ( ) _____

Address:

_____

City: _____ State: _____ Zip: _____

I hereby authorize disclosure of the health information for the above named patient. I understand that this authorization shall become effective immediately and shall remain in effect until three months from date of signature, or until I revoke it, in writing, whichever occurs first. Additionally 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 law. I understand and accept the statements contained in this authorization.

Print Name: _____

Signature: _____ Date: _____ Time: _____ am/pm

If signed by other than patient, please indicate relationship: _____

Witness Name: _____ Signature: _____

FACSIMILE NOTICE:
This notice is intended only for the use of the individual or entity named above and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication by error, please notify us immediately.