PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

MEDICAL RECORDS RELEASE FOR THE ROSE

By signing this authorization, I authorize The Rose to:

- Use and/or disclose certain protected health information (PHI) about me for the purposes of health care operations. This may include business management activities, general administrative functions and clinical management, such as to obtain a referral, quality assurance, quality improvement, case management, training programs, licensing, credentialing, certification, accreditation, compliance programs, research, fundraising and marketing activities that support the Rose and ensure that quality care is delivered.
- **Obtain all of my previous mammogram/ultrasound films and/or electronic cd images and their corresponding reports to be released for comparison studies. Please forward previous films and/or electronic cd images and reports to Attn: Medical Records The Rose Galleria 5420 West Loop South, Ste. 3300, Bellaire, TX 77401, 281-484-4708, 713-668-3173**

  Patient Name: _____ Date of Birth _____

  Name of Facility & Year of previous mammogram: _____
- **Obtain any reports involving additional testing based on recommendations by the interpreting radiologist.**
- **I hereby voluntary consent to coordination of services to accomplish care and treatment. I acknowledge that no guarantees have been made as to the results of treatments or examination. You are hereby authorizing The Rose to view your BCCS clinical services/data history if it has been stored in the MED-IT/B&C module.**

  _____.

  Patient Signature

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of my information. This authorization will expire one year from the date signed below. The Rose will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

HIPAA does not require you to sign this authorization in order to receive treatment from The Rose. However, it is the policy of The Rose that every patient is required to provide the name of their treating physician to receive a copy of their report and therefore authorizing The Rose to release medical records.

I have the right to refuse to sign this authorization for the specific reasons stated here and to whom the limits apply, other than the release of medical records: _____

_____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Rose Privacy Officer at: **5420 W. Loop S., Ste. 3300, Bellaire, TX 77401. Fax 713-668-3173. Please forward previous films and/or electronic cd images withf reports to the same address Attn: Medical Records.**

Signed by:_____ _____

Signature of Patient or Legal Guardian — If Legal Guardian -Relationship to Patient

_____ _____

Print Patient's Name — Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I received a copy of The Rose's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____

Name of Patient or Personal Representative — Signature of Patient or Personal Representative

FOR OFFICE USE ONLY

_____ _____Refused to sign

Date — _____ Witnessed