

The Center for Breast Health 

Patient Name: _____

Address: _____

Date of Birth: _____

Phone: _____

I hereby authorize _____

To release all my prior medical records to Danielle Duchini, D.O. Specific records to be released and time period:

_____ The purpose of need to release is:

Continuing of Care

Billing or Insurance Processing

Other

I specifically authorize the disclosure of the following type(s) of information if it is included within the information requested above:

Drug and Alcohol Abuse Treatment Mental Health HIV status

This authorization will expire upon the following dates or events:

I understand I have the right to revoke this authorization at any time. I may revoke it to the extent that Dr. Danielle Duchini has already relied upon it, or if this authorization was signed as a condition of obtaining insurance coverage. In order to revoke *this* authorization, I understand that I must revoke it in writing to Dr. Danielle Duchini, The Center for Breast Health.

I understand this information used or disclosed by Dr. Danielle Duchini, The Center for Breast Health to any other person(s) under this authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy provided to me by the law.

I understand that Dr. Danielle Duchini, The Center for Breast Health *may* not require that I sign this authorization in order to obtain treatment.

Date: _____ Patient Signature: _____

If you are the legal representative of the person listed above, please circle the basis for your authority and attach proof of authority

Power of Attorney Guardian Parents of Minor Executor/Administrator Other

Signature: _____ Date Signed: _____