FILM/REPORT RELEASE

Section A: This section must be completed **Good Samaritan Breast Care Center**

Patient Name	Today's Date	Pt ID No.

Phone No.	Date of Birth	Type of Films	Date of Exam	No. of Films

Released To

Physician Name (First & Last)	
Address:	
City, State, Zip Code	Phone No.

Method of Release ☐ Patient to pick-up - Date_____ ☐ Mail out ☐ Courier

We are pleased to provide you with these films and they are released with the understanding that they are part of our permanent patient records and property of this Facility. Please return within 30 days. **DO NOT loan them to a third party.**

The charges paid to this Facility and its Radiologists by the patient for mammography imaging service entitles the patient to an INTERPRETATION and a PERMANENT RECORD to be kept in our files. We are legally responsible for this record and therefore, the original imaging films **MUST BE RETURNED,** unless the patient has signed a permanent release to maintain the films in their possession.

Temporary release of these films to your physician, or to you releases this Facility from the legal responsibility for maintaining these films as part of your medical record, until such time as they are retuned to us by you or your physician.

This authorization will expire on - (If date is not specified the expiration date will be 60 days after this authorization was signed.) Date: _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing? ☐

If yes, the health plan or health care provider must complete section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	**Date:**
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**

Return Films To: Good Samaritan Breast Care Center
15400 National Avenue, Suite 200
Los Gatos, CA 95032

Copy to Facility, Send with Films

GOOD SAMARITAN HOSPITAL

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