CARE STAFF MEMBER: _____

DATE FAXED: _____

8903 GLADES ROAD SUITE H1
BOCA RATON, FL 33434
PHONE: 561-361-7872 FAX: 561-361-7873

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

** BY SIGNING THIS FORM THE PATIENT LISTED BELOW GIVES FULL MEDICAL RELEASE AUTHORIZATION TO THEIR PRIOR FACILITY LISTED BELOW TO RELEASE ANY/ALL MEDICAL RECORDS TO **CARE DIAGNOSTICS**.**

PATIENT NAME: _____ DOB: _____

MAY BE UNDER OTHER OR MAIDEN NAME: _____

PRIOR FACILITY NAME: _____

PHONE: _____ **FAX:** _____

REQUESTING: UP TO **5 YEARS OF BREAST RELATED RECORDS**

BREAST RELATED RECORDS INCLUDE
-MAMMOGRAMs -BIOPSYs
-ULTRASOUNDs -MRIs
-PATHOLOGY -ER/ PR/ HER2/ FISH ANALYSIS
ETC.

- PLEASE INCLUDE **THE PRINTED REPORTS & IMAGES ON CD** (DICOM FORMAT)
- PLEASE **DO NOT** MAIL **ENCRYPTED** OR **PASSWORD PROTECTED CDs!**

☐ **PLEASE MAIL STAT!!!!**

PATIENT SIGNATURE: _____ **DATE:** _____

IT IS THE PATIENT'S FULL RESPONSIBILITY TO CONTACT OUR FACILITY TO FOLLOW UP ON THE STATUS OF THEIR PENDING MEDICAL RECORDS REQUEST IF IT TAKES LONGER THAN 2 WEEKS TO RECEIVE VIA MAIL. (INCASE RE-REQUEST IS NEEDED)