HIPAA AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I hereby authorize:			**To disclose to:**		
%Site_Name%			BWC		
Name of Disclosing Party			Name of Recipient		
%Site_Address%			2500 Hospital Drive, Building 15, Suite 1		
Address			Address		
%Site_City%	%St%	%Zip%	Mountain View	CA	94040
City	State	Zip	City	State	Zip

Records and information pertaining to:

%Patient_Name%	%DOB%	%MRN%
Patient Name	Date of Birth	Medical Record Number

Purpose of this release: Personal access to your breast imaging and pathology patient records.

Specific Records: If you give your permission and sign this form, you are allowing the disclosing party to release the following medical records containing your Personal Health Information.

- Breast Imaging DICOMs
- Breast Imaging Reports
- Breast Pathology Reports

Your Personal Health Information includes health information in your medical records, financial records and other information that can identify you.

Records & dates to disclose: All available records are to be disclosed.

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature. You may also authorize the release of information for services provided after the date of the signature on this Authorization as long as such services occur while this authorization has not expired. Please initial if you would like this Authorization to release information about healthcare you receive after the date of your signature. %initials% (Initial here)

Revocation: This authorization is also subject to written revocation by you, the patient, at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from the patient or unless such use or disclosure is specifically required or permitted by law. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. A copy of this authorization is valid as the original. Patient has a right to a copy of this authorization.

%Date%	%Signature%	%Relationship%
Date	Signature	If signed by other than patient indicate relationship

BWC HIPAA COMPLIANT AUTHORIZATION FORM (11/28/2018)