**Authorization for Release of Protected Health Information**

**The Katherine M. Cyran M.D. Breast Center**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Requested**: \_\_\_\_\_\_\_\_\_\_\_\_

**Information Requested**

*I authorize the release of health information contained in my medical records including*:

 Prior Breast Imaging Studies (Mammograms-at least two years, Ultrasounds)

 Prior Reports (please Fax)

*I would like these sent*:

 By mail

 Electronically (Powershare, AstraPlus, Other)

*I would like these sent*:

FROM: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: Katherine M. Cyran M.D.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3360 Tremont Road,

Suite 130

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Columbus OH 43221

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P: 614.459.1596

**F: 614.459.1471**

 *I would like these to be a permanent transfer*

Purpose of Disclosure: (check one)

 Comparison/Continued Patient Care Insurance Personal Use Disability

It is further understood that their information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization, or person.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it. This authorization will expire 60 days from the date signed.

I understand that health information that is released under this authorization may be subject to re-disclosure by the recipient, and the privacy of my health information may no longer be protected by the law. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this authorization, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

A faxed copy of this authorization shall have the same effect as the original.

A fee for copying records is due upon request or receipt if records are copied for the patient. If records are copied for another physician’s office/hospital, there is no charge.

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Signature of Patient or Legal Representative Date Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Checked

Witness Date