North State Radiology

Chico Breast Care Center | North State Imaging
North State Interventional Radiology | North Valley Advanced Imaging

Authorization and Request for Release of Medical Records

I understand that North State Radiology will not condition treatment or payment on my providing or refusing to provide this authorization.

PATIENT NAME:_____ **DOB:** _____

I hereby authorize:

_____
NAME OF DISCLOSING PARTY

_____
ADDRESS CITY STATE ZIP

To disclose to:

☐ Chico Breast Care Center	FAX: (530) 898-0533	PHONE: (530) 898-0502
☐ North State Imaging	FAX: (530) 898-0515	PHONE: (530) 898-0500
☐ North State Interventional Radiology	FAX: (530) 893-9761	PHONE: (530) 898-0520
☐ North Valley Advanced Imaging	FAX: (530) 894-0174	PHONE: (530) 894-6200

Records and information pertaining to:

_____
PATIENT NAME (print) **DATE OF BIRTH**

Specify the records to be disclosed:_____

_____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

REVOCATION: This authorization is also subject to written revocation by 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: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

X_____ _____
Signature **Date**