North State Radiology

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

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: ___________ MRN:___________

I hereby authorize:

☐ Chico Breast Care Center
☐ North State Imaging
X North State Interventional Radiology
☐ North Valley Advanced Imaging

To disclose to (facility / provider name):

____
Name
____
Address
____
City State Zip

Please check appropriate box for the Medical Information that you are requesting:

☐ Medical Imaging Reports Only

☐ Medical Images and reports on CD

Records pertaining to: ____

Employee signature below confirms that the patient's ID was verified prior to the release of records:

Employee signature: ____

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**