



North State Radiology

Chico Breast Care Center | North State Imaging | 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
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To disclose to:

- Chico Breast Care Center FAX: (530) 898-0533 1720 Esplanade Chico, CA 95926
- North State Imaging FAX: (530) 898-0515 1720 Esplanade Chico, CA 95926
- North Valley Advanced Imaging FAX: (530) 332-2964 1638 Esplanade Chico, CA 95926

Records and information pertaining to:

PATIENT NAME (print)	DATE OF BIRTH
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Specify the records to be disclosed: _____

PLEASE FAX OR MAIL RECORDS WITHIN 24-48 HOURS FOR EFFICIENCY OF CARE

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

REVOCAATION: 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.

REDISCLASURE: 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**