BRIDGE BREAST NETWORK

Authorization for Use and Disclosure of Protected Health Information

When you obtain services from any Bridge Breast Network provider, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. You may request a copy of the Bridge Privacy Policy and Practices at any time. You have the right to request that we restrict how protected health information about you is used.

I authorize the healthcare provider listed below to release my medical records and imaging studies to the Bridge Breast Network fax to: (214) 821-0869

	FOR OFFICE USE ONLY

I understand no information pertaining to my medical visits will be disclosed to anyone for purposes outside of normal treatment, payment, and program operations. I understand that I will be responsible for informing those people that I wish to be aware of reasons for my medical visits. Further, I understand The Bridge Breast Network and its providers are not responsible for any disclosures regarding my medical condition and/or treatments that are made by people that I inform.

1) This restriction will have no impact on the Bridge Breast Network right to disclose and use my protected health information for purposes of treatment, payment and health care operations.
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying the Bridge Breast Network in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) The Bridge Breast Network agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

☐ I authorize the Bridge Breast Network to use my story but not my full name for operational and fundraising purposes.

Additional Disclosure:

I also authorize The Bridge Breast Network to discuss my medical history, diagnosis and treatment with the following:

Relationship	Name	Phone Number
☐ Spouse	_____	_____
☐ Child	_____	_____
☐ Child	_____	_____
☐ Parent(s)	_____	_____
☐ Other: _____	_____	_____

Expiration:

This authorization will expire 180 days from the date of signing or **(insert date)** _____.

Patient Name: _____ **Patient ID #:** _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Printed Name of Patient's Representative (*if applicable*) **Relationship to Patient (*if applicable*)**