Georgia
Breast Care

Welcome
&
Patient Instructions

Welcome to Georgia Breast Care!

Thank you for giving us the opportunity to take care of your health care needs.

In order to provide the best service to you at the time of your visit, please go to our patient portal and complete the necessary information ***or*** you may also visit our website at: **www.georgiabreastcare.com** to print out the forms to complete, **or** you may complete the forms at our office.

*If you are an **established patient**, please arrive **15 minutes before** your scheduled appointment to update necessary paperwork. You may go to our website and print the established patient paperwork to complete and bring it to your appointment.*

*If you have been referred to our office for a biopsy, your first appointment at our office is for consultation **only.***

In addition:

- Please bring ***Current insurance cards*** so the office can make a copy, ***Photo ID*** such as driver's license or other government issued identification, & ***Current list of medications & dosages*** including over-the-counter, herbal, and supplement medications as well as dosage. This current list will be needed for ***every*** visit to our office.
- A ***referral*** form from your primary physician including their fax/phone number, ***if required*** by your insurance carrier. **If you are not sure if you need a referral, please contact your insurance carrier *prior* to your visit.**
- If you are coming to our practice for a ***second opinion***, we will need films, surgical reports, pathology reports, and genetic testing if performed.
- Payment for your visit is expected at the time of the visit including co-pays. Claims will be submitted by our staff. For self-pay patients or patients with non-participating insurances, full payment is due at the time of the visit. We accept cash, checks, and debit/credit cards including Visa, MasterCard, Discover, and American Express. Additional information is provided in our "Financial Policy and Authorization" document.
- For office procedures requiring lab/pathology services, you will receive a ***separate statement*** from other facilities.
- We ask that you ***call our office 3 business days prior to your appointment*** if you need to ***cancel or reschedule*** your appointment. Failure to do so will result in a ***$50 charge*** to you that is non-refundable.
- If you arrive late or are delayed by referral issues, you may miss your appointment time and be required to reschedule.
- Please bring a sweater/coat. Our office is kept cool to protect and ensure the proper function of medical equipment.
- ***VISITORS ARE NOT ALLOWED IN OUR OFFICE.*** *(visitor exceptions for minor or impaired patients ONLY; any other accommodations will need management approval **prior** to appointment)*

Thank you,

KAREN BUHARIWALLA, DO
Kimberly Pinto, PA-C
Diana Bishop, NP-C

900 Towne Lake Pkwy ✕ Suite 312 ✕ Woodstock, Georgia 30189
678.370.0370 ✕ fax: 678.370.0371 ✕ email: info@georgiabreastcare.com

Georgia Breast Care

PATIENT INFORMATION

TODAY'S DATE: ____ / ____ / ____ REFERRING PHYSICIAN:

OB/GYN PHYSICIAN: PRIMARY CARE PHYSICIAN:

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB: ____/____/____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP : _____

CELL #: ( ) _____ HOME #: ( ) _____ WORK #: ( ) _____

May we leave a message on these contact numbers? yes no EMAIL ADDRESS: _____

LANGUAGE: English Spanish Other: _____ ETHNICITY: Hispanic/Latin Not Hispanic/Latin Decline to specify

RACE: African-American Asian Hispanic Native American White Other: _____

GENDER: Male Female Transgender Male Transgender Female Decline to answer SEX ASSIGNED AT BIRTH: Male Female

PRONOUNS THAT YOU PREFER WHEN TALKING WITH YOU: She/her/hers He/him/his They/them/theirs Other - Please specify: _____

MARITAL STATUS: Single Married Widowed Divorced Legally Separated

LAST 4 DIGITS OF YOUR SOCIAL SECURITY #: _____ _____ _____ _____

EMPLOYER NAME: _____

INSURANCE INFORMATION

INSURANCE CARRIER: _____

SPECIALIST CO-PAYMENT AMT: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: ____/____/_____

RELATIONSHIP TO INSURED: Self Spouse Child Other: _____

IN CASE OF EMERGENCY

NAME OF CONTACT: _____ RELATIONSHIP TO PATIENT: _____ PHONE #: _____

NAME OF CONTACT: _____ RELATIONSHIP TO PATIENT: _____ PHONE #: _____

PHARMACY

PHARMACY NAME : _____ ADDRESS: _____ PHONE #: _____

I authorize Georgia Breast Care, PC and its affiliated providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff at Georgia Breast Care, PC. It may include prescriptions from the past several years.

My signature below certifies that I have read and understand the scope of my consent and I authorize access. The above information is true to the best of my knowledge. Also, we will file insurance with your provider according to your individual plan.

_____ _____

PATIENT SIGNATURE OR AUTHORIZED SIGNATURE DATE

Georgia Breast Care

Notice Patient Consent of Privacy Practices & Authorization for Use & Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** ____ /____ /____ **Last 4 of SS#** ___ ___ ___ ___

STATEMENT

I understand that according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that I have certain patient rights regarding my protected health information. I understand that Georgia Breast Care, PC may use or disclose my protected health information for treatment, payment, or health care operations; which includes providing healthcare to me, the patient, handling billing and payment as well as taking care of other health care operations. The patient or legal custodian authorizes the Staff Physician(s), Nurse Practitioner, and/or Physician Assistant to examine and treat the above patient. I understand Georgia Breast Care will not condition my treatment on whether I provide authorization. This authorization will automatically renew. Georgia Breast Care, PC has a detailed document called the *Notice of Privacy Practices* which contains a more complete description regarding your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to review the Notice of Privacy Practices before signing this agreement. If I ask, Georgia Breast Care will provide me with the most current Notice of Privacy Practices. With authorization, Georgia Breast Care may call, leave a message, voice mail, or send a text message that will aid the practice in carrying out treatment, payment and health care operations. The patient has the right to revoke this authorization at any time in writing except to the extent that Georgia Breast Care, PC has taken action relying on consent. This authorization will remain in effect unless otherwise revoked by the patient. Release of the PHI covered by this authorization will be disclosed solely for the purpose of keeping designated family members informed of your healthcare condition.

ADDRESS:
Georgia Breast Care, PC
Attention: Practice Administrator
900 Towne Lake Pkwy • Suite 312
Woodstock, Georgia 30189

Phone: (678) 370.0370 Fax: (678) 370.0371

INDIVIDUALS TO WHOM YOUR HEALTH INFORMATION MAY BE DISCLOSED

☐	Spouse	Name: _____	Phone: _____
☐	Child	Name: _____	Phone: _____
☐	Child	Name: _____	Phone: _____
☐	Parent	Name: _____	Phone: _____
☐	Parent	Name: _____	Phone: _____
☐	Other	Name: _____	Phone: _____

TYPE OF INFORMATION THAT CAN BE DISCLOSED

- ☐ **All** at doctor's discretion
- ☐ Medical History
- ☐ Diagnosis
- ☐ Treatment
- ☐ Billing/Insurance Information
- ☐ Surgical Information
- ☐ Other: _____

_____ _____

Patient or Authorized Signature **Date**

The personal health information contained on this form is intended only to aid in providing healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. If you have received this form in error, please contact our office at (678) 370.0370 and shred this document.

Georgia
Breast Care

Financial Policy
&
Authorization form

Thank you for choosing Georgia Breast Care, PC! We are committed to meeting your healthcare needs. Georgia Breast Care accepts most insurance plans; however, it is the patient's responsibility to confirm with our office and the insurance carrier.

INSURANCE PAYMENTS: Insurance is a contract between you and your insurance company. You are ultimately responsible for payment of the charges for services received from Georgia Breast Care, PC, including those covered by your insurance. As a convenience, Georgia Breast Care, PC will submit claims for reimbursement with your insurance provider. It is your responsibility to provide the most current insurance information available as well as any changes in your address, name, telephone information, or email address at each visit. If Georgia Breast Care is provided with incorrect insurance information, you will be responsible for the remaining balance. Your insurance carrier makes the final determination of your eligibility and benefits. To satisfy your financial obligation, you agree to provide Georgia Breast Care, PC and/or its designated payment agent with your debit/credit card, ACH information, cash, check, or money order. We accept VISA, MasterCard, American Express, and Discover.

MEDICARE: We accept Medicare assignment. If you have a supplemental insurance, we will bill it directly. If you have a Medicare Advantage plan, you are required to pay your co-pay at the time of service. Medicare patients are responsible for their annual deductible and co-insurance.

PATIENTS WITH A HMO: It is your responsibility to know and understand your HMO medical plan. If your HMO requires a ***referral*** for a consultation, you are responsible for obtaining it and submitting it to us ***prior*** to your visit. Also, it is your responsibility to confirm with your insurance company that we are in network with your plan. If you do not have a referral for today's visit, it is recommended you reschedule your appointment.

PATIENTS WITH A PPO: You are responsible for your co-pay, deductible, and your co-insurance. Co-payments are due at the time of your visit. It is your responsibility to verify with your insurance carrier that we are contracted with your plan.

SELF-PAY: You are required to pay the self-pay rate at the time of your visit.

PAYMENT POLICY: Payment is expected in full within 30 days of receipt of your patient statement. You may generally expect this billing statement within 20 days after your insurance company has responded to a submitted claim. If payment is not received within 60 days, your account is considered past due. The policy of this office is to only send 2 statements. The statements are sent at approximately 30-day intervals. If no payment is received on your account during the 60-day grace period, your account will be turned over to collections without additional notice.

PAYMENT PLANS: Georgia Breast Care, PC is willing to work with you to assist you in paying your outstanding balance. We do have an established payment plan program for an outstanding account balance. Balances may be divided into no more than 4 monthly payments. A valid credit/debit card must be presented at the time the plan is established. Your signature on our payment plan form is required. Your signature acts as your authorization for us to charge your card on a monthly basis. This authorization remains in effect until the outstanding balance is zero.

SURGERY CHARGES: Prior to surgery, Georgia Breast Care will contact your insurer to obtain pre-certification and verify benefits. This process does ***not*** guarantee payment by your insurance carrier. You agree to facilitate payment of claims by contacting your insurance carrier when necessary.

IN-OFFICE PROCEDURES: Georgia Breast Care, PC will contact your insurer to obtain pre-certification and verify benefits as well as ***estimate*** your out-of-pocket expenses based on your coverage and benefits. You will be required to pay in full this amount ***prior*** to the procedure. This process is not a guarantee of your final out-of-pocket expense for the procedure.

SURGICAL CANCELLATIONS: If you need to reschedule/cancel a surgical procedure, a 3-business day notice is required. Failure to cancel the procedure by notifying our office may result in a $150.00 non-refundable administrative fee. This fee must be paid before rescheduling.

OUT OF OFFICE SURGICAL PROCEDURE: You will receive a statement from Georgia Breast Care, PC for the physician's fee for your surgical procedure. Also, you will be billed separately by the surgical center for their facility charges. Additionally, if a specimen is sent to a lab for analysis, you will receive a bill from the lab. Finally, if you receive anesthesia services, you will receive a statement from the anesthesiologist. Georgia Breast Care, PC does not handle charges billed for the facility, lab, or anesthesiologist.

LAB SERVICES AND OTHER ANCILLARY SERVICES: Depending on the services provided, you may receive statements for ancillary services. Please understand that we cannot know which tests are covered by your individual insurance as each insurance plan is different. Also, we send all lab specimens to an outside lab, and the lab will bill you separately. Please advise in advance if your insurance plan requires a specific lab. For anesthesia or lab services, please direct any questions or disputes to their billing offices. Each of these charges will be based on your insurance coverage and benefits.

RETURNED CHECK FEE: A 35.00 fee will be assessed on all returned checks.

CO-PAYS: We are required to collect co-pays, deductibles and co-insurance per our contracts with insurance carriers. These amounts cannot be negotiated or waived. **Co-pays are expected at the time of service**. If you are unable to pay your co-pay, you will need to reschedule your appointment.

CODING CHANGES FOR SERVICES PROVIDED: Many insurance companies have restrictions on the type of services that are covered by their policies. Government regulations dictate that all health care providers must submit claims that accurately reflect the services that are provided as well as documented in the patient's medical record. Our office is under strict guidelines that demand we code services/orders to the highest level of accuracy. **Please do not ask our staff to change coding or diagnosis codes for the purpose of getting your insurance to make payment on services rendered**.

We strive to provide excellent medical care to you and to all our patients. Consistent with this, we have developed missed appointments, late cancellation and no show policies that allow us to better schedule appointments for all patients. When an appointment is scheduled, that time has been specifically reserved for you and when it is missed, that time cannot be used to treat another patient in need of care. We sincerely appreciate your assistance and cooperation as this allows for a smooth office flow and more efficient use of your time.

MISSED APPOINTMENT FEE: Failure to cancel an appointment 3 business days in advance will result in a $100.00 fee.

LATE ARRIVAL FOR APPOINTMENT: If you arrive late for your appointment, it is highly unlikely that we will be able to offer you an appointment the same day and your account will be assessed a $100.00 fee. We realize that some

events such as traffic and other emergencies occur. Please call our office to speak with our staff as soon as possible in this situation.

CANCELLED APPOINTMENTS: For our returning patients, we provide an appointment reminder card at the conclusion of your visit for your next visit. As a courtesy to our patients, we send out a text confirmation message 7 days prior to your appointment. The text message will allow you to confirm or cancel your appointment. If you do not respond to the text message, you will receive another text message 6 days prior to your appointment that will allow you to confirm or cancel your appointment. It is very important that we have up to date contact information so that you will be able to receive communication from our office. If you do not cancel your appointment, we will assume that you will be attending your appointment and prepare accordingly. If you fail to provide our office with the courtesy of cancelling or rescheduling your appointment at least 3 business days, your account will be assessed a $100.00 fee.

REPEAT CANCELLATION/RESCHEDULE/NO SHOW OF ESTABLISHED PATIENT: Established patients who have an excessive history of late cancellations, missed appointments, or a combination of the two will be subject to discharge from the practice. Ultimately, it is your responsibility to keep up with your scheduled appointment. You are always welcome to call our office for any clarification or rescheduling needs. Also, your patient portal will have your appointment information for your use as well. In addition, you are able to submit a cancel/reschedule request via your patient portal.

COMMUNICATION METHODS FOR PATIENT ACCOUNT: Georgia Breast Care, PC may contact you with any phone number associated with your account, including wireless numbers which could result in charges to you. In addition, you may be contacted via mail, email, text message, a pre-recorded/artificial voice message, and/or use of an automated dialing service as applicable.

QUESTIONS: *If you have any questions about Georgia Breast Care's financial policy or your insurance authorization/reimbursement, you may discuss them with Georgia Breast Care's business office staff.*

AUTHORIZATION:

- I authorize the release of any medical information necessary to process a medical claim to my insurance company.
- If my insurance carrier denies my claim and I choose to appeal the decision, Georgia Breast Care may submit an appeal with any necessary medical information to my insurance company on my behalf.
- I authorize Georgia Breast Care, PC to charge my copay and/or account balance to my credit/debit card with the information provided by me.
- I authorize that Georgia Breast Care's Notice of Privacy Practices has been made available to me. I have the opportunity to ask questions as needed.

I have read and understand my financial responsibilities under this policy. This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify Georgia Breast Care, PC in writing of any changes in my payment or other information.

_____	____/____/_____	____/____/_____
Patient Name (print)	**Date of Birth**	**Date**
_____	_____	
Patient Signature	**Responsible Party (if not the patient)**	

900 Towne Lake Pkwy ✕ Suite 312 ✕ Woodstock, Georgia 30189
678.370.0370 ✕ fax: 678.370.0371
email: info@georgiabreastcare.com

Georgia Breast Care

BREAST & MEDICAL HISTORY

PATIENT NAME: _____ DOB: ____/____/____ REFERRING PHYSICIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP : _____ PHONE: _____

DATE OF LAST CLINICAL/PHYSICAL BREAST EXAM: _____ HEIGHT: _____ WEIGHT: _____ BRA SIZE: _____

REASON FOR VISIT

Abnormal Mammogram:	yes	no	Right	Left	Duration of complaint: _____
Lump:	yes	no	Right	Left	Duration of complaint: _____
Pain:	yes	no	Right	Left	Duration of complaint: _____
Nipple Discharge:	yes	no	Right	Left	Duration of complaint: _____
Change in Breast Appearance:	yes	no	Right	Left	Duration of complaint: _____
Second Opinion:	yes	no	Right	Left	Duration of complaint: _____

BREAST IMAGING

Mammogram: yes no **Ultrasound:** yes no **MRI :** yes no

Date: _____ **Date:** _____ **Date:** _____

Facility: _____ **Facility:** _____ **Facility:** _____

PRIOR BREAST SURGERY *(if applicable)*

Breast implants : yes no **Reduction:** yes no

Biopsy: yes no **If yes,** right left **Type:** needle surgical **History of atypia:** yes no

BREAST CANCER TREATMENT *(if applicable)*

Lumpectomy: yes no Right Left

Radiation: yes no Date: _____

Mastectomy: yes no Right Left **Reconstruction:** Right Left

Chemotherapy: yes no Date: _____

GENETIC TESTING *(if applicable)*

Genetic testing: yes no

If yes, Where: _____ Date: _____ Results: _____

Has any member of your family had genetic testing: yes no

If yes, Where: _____ Date: _____ Results: _____

MEDICATIONS

CHECK HERE IF **NONE** *include: over-the-counter medicines, vitamins, herbals and supplements*

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

I take aspirin or blood thinners.

Please specify type & dosage : _____

I take a steroid.

Please specify type & dosage: _____

Should you require additional space for medication list, please check here and write on the back of this page.

ALLERGIES

CHECK HERE IF **NONE**

MEDICATIONS _____

LATEX LIDOCAINE IODINE CONTRAST MATERIAL MRI CONTRAST ADHESIVE TAPE

OTHER: _____

PAST SURGERIES

CHECK HERE IF **NONE**

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

SURGERY: _____ **DATE:** _____

PAST MEDICAL HISTORY

*Please **MARK** all that apply.*

BLOOD/ONCOLOGY: Anemia Bleeding/Clotting Disorder Blood Clot HIV/AIDS Cancer: type _____

CARDIAC: High Blood Pressure Heart Failure Stents Heart Bypass Atrial Fibrillation Pacemaker/Defibrillator Heart Attack Arrhythmia Heart Murmur

URINARY: Frequent urinary tract infections Kidney Stones Dialysis: Days _____ Kidney Disease: _____

RESPIRATORY: Asthma Tuberculosis/Positive TB test Emphysema/COPD Pulmonary Embolism Sleep Apnea

AUTOIMMUNE: Lupus Other: _____

NERVOUS: Headaches Anxiety/Depression Stroke Seizure

MUSCULOSKELETAL: Fibromyalgia Arthritis Joint Replacement

GASTROINTESTINAL: Hepatitis B or C Ulcer Acid Reflux Disease GI bleeding Diverticulitis

ENDOCRINE: Diabetes Thyroid Disorder **EYES/EARS/NOSE:** Glaucoma Hearing Loss Vision Problems

REVIEW OF SYSTEMS

*Please **MARK** all that apply.*

CONSTITUTIONAL: Weight Gain Weight Loss Fevers Sweats

ENDOCRINOLOGY: Heat/Cold Intolerance Excessive thirst/urination

NEUROLOGY: Weakness Dizziness Gait problems Memory problems Use a cane, walker, or wheelchair

EARS/NOSE: Vertigo Hearing Aid

EYES: Glasses/Contacts

RESPIRATORY: Cough Wheezing Shortness of Breath

HEMATOLOGY/LYMPHATIC: Bruise easily Enlarged glands

SKIN: Rashes Sores Itching

GENITOURINARY: Burning/Painful Urination Blood in Urine

CARDIOVASCULAR: Chest pain/angina Palpitations Leg swelling

GASTROINTESTIONAL: Loss of appetite Heartburn Rectal Bleeding/Blood in Stool

MOUTH/THROAT: Dentures Bleeding gums Voice Change

MUSCULOSKELETAL: Joint/Back pain Muscle aches Stiffness Swelling

SOCIAL HISTORY

Tobacco use: yes no **Alcohol use:** yes no **Caffeine:** yes no

Packs/Day: ____ **Years:** **Daily Weekly Occasionally** **Cups/per day** ____

Former Smoker: yes no **Year quit** _____ **Quantity:** _____ **Coffee Tea Soda Chocolate**

GYNECOLOGICAL/OB HISTORY

Menstrual History: Age at onset: ___ Age at Menopause: ___ Age of Last Menstrual Period: ___ Age at Hysterectomy: ____

First day of Last Menstrual Period: ____/____/____

Gynecological History: Uterus removed One Ovary removed Both Ovaries removed

Hormonal Therapy: Birth Control : _____ Fertility Treatment: _____

Hormone Replacement Therapy: Current Never Used in the past: How long? _____ When quit? _____ Type: _____

Childbirth History: # of Pregnancies: _____ # of Children: _____ Age at 1st Childbirth: _____ **Breastfeed:** yes no

History of Breast Biopsy: yes no ***If yes:*** right left needle core biopsy surgical biopsy Date: _____

MALE PATIENTS

Testicular mass: yes no

Recent testicular exam by a physician: yes no

FAMILY HISTORY

Family History of Breast Cancer: yes no

***If yes**, please list family member & their age at diagnosis:* _____

_____

Family History of Colon, Ovarian, Pancreatic, Prostate Cancer or Melanoma? yes no

***If yes**, please list family member & their age at diagnosis:* _____

_____

Ashkenazi Jewish or Eastern European Ancestry: yes no

PHARMACY

Pharmacy Name: _____ **Address:**_____

Phone: _____

I authorize Georgia Breast Care, PC and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff at Georgia Breast Care, PC. It may include prescriptions from the past several years.

My signature below certifies that I have read and understand the scope of my consent and I authorize access.

CONSENT & RELEASE

This consent covers all the medical services rendered to me by the providers at Georgia Breast Care, PC. Patient or legal custodian of those individuals that are under the age of 18 authorizes the Staff Physician(s), Nurse Practitioner, or Physician Assistant to examine and treat the above patient. The duration of this consent is indefinite and will continue until revoked. I understand I may revoke this consent by informing the practice in writing. If I do revoke this consent, it will not affect anything done prior to the date the revocation is received.

CONSENT FOR TREATMENT: I have voluntarily presented to Georgia Breast Care, PC for consent to treatment of me by the practice and its staff, including its physicians, physician assistants, nurse practitioners, and other employees, providers, and staff members. Care may include; but, it is not limited to: general treatment, use of prescribed medications, performance of diagnostic procedures, test and cultures, and performance of other laboratory tests that my physician or his/her designee determines medically necessary or advisable based upon my treatments or examinations and I understand that all medical treatments contain inherent risks. I understand that my consent is voluntary, if I refuse to sign this consent, the practice may refuse to treat me except in a case of emergency.

CONSENT FOR HEALTH INFORMATION EXCHANGE: I hereby acknowledge and consent that Georgia Breast Care will share my medical information, as permitted under federal law (HIPAA) and Georgia State Law, with my healthcare providers through a health information exchange.

CONSENT FOR PHOTOGRAPHY: I consent to have my image taken by the practice and understand that my photographs, digital, and other images will become part of my medical record and therefore protected, used and/or disclosed in accordance with practice's Notice of Privacy Practices. I understand that the practice will own these images. In addition, to ensure your confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices.

☐ Please initial here if you ***decline*** to have your photograph taken for identification in your electronic medical record.

The undersigned patient or authorized individual acting on behalf of the patient, understands and agrees as follows:

_____ _____

PATIENT SIGNATURE or AUTHORIZED SIGNATURE **DATE**

MediCopy
an MRO company

Georgia Breast Care

MediCopy Authorization for the Release of Medical Records

Where are the records being released from?

Facility Name: Provider Name(s):

Address: City: State:

Tell us about the patient.

Name: DOB: SSN: XXX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released? Check all that apply.

☐ All Records ☐ Office/Clinic Notes ☐ Operative Reports ☐ Psychological/Psychiatric, if any

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Immunization Records ☐ Substance Abuse, if any

☐ Last Two Years of Records ☐ Dates _____ to _____

☐ Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Continuation of Care ☐ Transfer to New Physician

Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ Postage (additional fee applies)

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: Date:

Relationship to patient: