Pinehurst Medical Clinic

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Patient Name: _____ **Patient DOB**: _____

I request and authorize my previous mammography medical records and images to be retrieved and released for comparison from:

Facility: Morgan Records Management – Custodian of Pinehurst Radiology Associates (PRA) Medical Records
Address: 8 State Street, Nashua, NH, 03063
Phone: (833) 888-0061

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me to ***Pinehurst Medical Clinic (PMC).***

Information Request: Please send **MOST RECENT 8 YEARS OF BREAST IMAGING.**

Important information: Morgan Records Management is the custodian of PRA's medical records, and my authorization allows PMC to request the release of my medical records and the retrieval of my medical records for a $35 charge.

Please check below noting how you would like to proceed.

____ I would like PMC to obtain my PRA medical record(s) and understand I will be financially responsible for Morgan Records retrieval fee of $35 which will be paid to PMC and submitted to Morgan Records on my behalf.

____ I do not want PMC to obtain my PRA medical record(s). I understand I will still be able to schedule my 3D mammography screening for breast cancer with PMC; however, I will have no images for comparison.

I understand that the medical record released pursuant to this authorization could contain information outside of the requested information stated above depending on my medical history with PRA. **PMC will only store the information that is part of the request stated above.**

Please check below noting how you would like to proceed.

____ I would like to receive a copy of my medical record(s) from Morgan Records, custodian of PRA's medical records. Please provide your preferred email address so your records can be delivered securely by Morgan Records.

Email: _____

If you do not have an email address or would prefer another delivery method, please reach out to Morgan Records directly, as there will be an additional charge for this service and processing.

Morgan Records: https://morganrecordsmanagement.com/

____ I would not like a copy of my medical record(s) from Morgan Records, custodian of PRA's medical records.

When my information is used or disclosed pursuant to this authorization, it may be Protected Health Information and subject to The HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health Care Provider. This authorization shall be in effect until two years from date of execution at which time this authorization expires.

Signed by: _____ Date: _____

Records should be mailed and/or faxed to:

Pinehurst Medical Clinic
Mammography Department
15 Regional Drive
Pinehurst, NC 28374
Fax (919) 706-4778