Consent to Release Medical Records

The Couri Center would like permission to request breast imaging reports and clinic/pathology/cytology reports from your medical records on your behalf. This may be prior records or records from potential additional procedures within the next year. You allowing this will help us in our quest to revolutionize breast imaging. **Please ensure you fill out all information, including fax number. If this is not completed, we are unable to receive your records.**

Please give your permission by completing and signing this form.

Patient Information:

- Last Name: ___________________________________
- First Name: ___________________________________ Middle Initial: ________
- Date of Birth (MM/DD/YYYY): _______________

Facility Authorized to Receive Health Information:

The Couri Center for Gynecology and Integrative Women's Health
6708 N Knoxville Ave Peoria, IL 61614
Phone: (309) 692-6838 Fax: (309) 691-6858

Facility Health Information is Requested From:

- Name of Facility: ___________________________________
- Medical Record Number (if known): _______________
- Address: ____
- Phone: ____________________ Fax: _______________

Dates of Service Release Authorization:

I authorize the release of the request for BREAST IMAGING REPORTS (any mammograms, ultrasound, and MRI) and BREAST CLINIC/PATHOLOGY/CYTOLOGY REPORTS from your medical records. All past, present, and future periods, up to **one year** after the signature date.

Patient Signature Authorization of Release:

- Name: ____
- Date: ____
- Signature: _______________________________________