COURI CENTER
for Gynecology and Integrative Women's Health

Consent for The Couri Center to Send Records to Another Facility

This document gives the Couri Center permission to send breast imaging reports to the facility of your choice on your behalf. This will help to facilitate the process of further evaluation in the event of an abnormal scan result. **You give your permission by completing and signing this form. Please ensure you fill out all information, including fax number. If this is not completed, we are unable to send your records.**

Patient Information:

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

Facility Authorized to Send 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 to Send Information To:

- 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 to the above-mentioned facility for continuation of care. All past, present, and future periods, up to **one year** after the signature date.

Patient Signature Authorization of Release:

Name: _____

Date: _____

Signature: _____