Tulsa Breast Center

Thermography Intake Form
Office Use Only! Filed _____ EMI# _____ Payment_____ Report ID_____

Name _____D.O. B. _____ Age_____

E-mail _____Mobile Phone _____
(future reminders will be sent by text)

☐ Please check if address is unchanged from last visit or,
If you have moved, please fill out the information below:

Address_____City_____St._____Zip_____

Occupation _____

1. **Date of Last Mammogram or Ultrasound (ONLY IF in last year) _____**
2. **Any vaccines in last 4 weeks? (circle one) NO Right arm Left arm**
3. **Please list any changes since last visit in the following areas:**
    - **Breast Health_____**
    - **Concerns _____**
    - **Medications _____**
    - **Symptoms_____**
    - **Clinical correlation_____**
    - **Diagnoses _____**
    - **Surgeries_____**
    - **Dental work_____**

Current Doctor: _____

Referring Practitioner:_____

***Signed*_____ Date_____**

Thermographer Signature: _____ (All Clinical Thermographers are trained and certified by the ACCT)

Authorization to Use or Disclose Protected Health Information

Tulsa Breast Thermography, LLC

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, *TULSA BREAST THERMOGRAPHY, LLC* **may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature or Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*