Healthcare Partners
A Holistic Medical Practice

BREAST THERMOGRAPHY

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As allowed by the Privacy Regulations, I wish to access the following information contained in my protected health records: (*Please be specific*)

THERMOGRAM

I would like the following access:

☐ **Review/Pick up**. I would like to make an appointment: ☐ to review report ☐ to pick up copies of the above-listed information.

☐ **Format**. I would like to receive the above-listed information in the following format (circle as applicable):
CD hard copies

☐ **I would like you to mail/fax** the above listed information to the following address or fax number:

_____

_____

_____

☐ **I would like you to mail or to give the above listed information to the following person.** I have completed and signed the authorization which is attached:

_____

Charges
I understand that I may be charged reasonable clerical costs and that you may charge a copy or other fee associated with this request. I agree to pay these costs prior to receipt of the requested information.

Response
I understand that you will either grant or deny this request within the prescribed time period (30 days if information is maintained on-site, 60 days if the information is maintained off-site. HEALTHCARE PARTNERS may extend the deadline by an additional 30 days if patient is notified in writing of the extension.) HEALTHCARE PARTNERS's response will be in writing with an explanation as required by the Privacy Regulations.

_____ _____
Signature Date

_____ _____
Authorized Signature of Facility Date

If this request is made by a personal representative on behalf of the individual, complete the following:
Personal Representative's Name: _____ Relationship to patient: _____
☐ A copy of my personal representative form or legal document is on file.
☐ Attached is a copy of my personal representative form or legal document.

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AUTHORIZATION TO USE OR DISLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name**:**_____

Address: _____

Date of Birth: _____ Date of Request**:**_____

As required by the Privacy Regulations, *HEALTHCARE PARTNERS* **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*

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BREAST THERMOGRAPHY

INFORMED CONSENT FOR BREAST THERMOGRAPHY

Instructions: PLEASE READ CAREFULLY. If you are in agreement with this consent form, please sign and date at the bottom. Please ask questions if there is anything that you do not understand on this consent form.

Thermography is simply a procedure utilizing thermal imaging cameras to visualize and obtain an image of the infrared radiation (heat) coming from the surface of the skin. The Thermographic procedure is performed as an aid to the evaluation of abnormal temperature patterns which may or may not indicate the presence of a disease process.

The thermographic procedure is NOT a standalone diagnostic tool. It is an adjunctive tool, which while reliable, should be used by the primary care physician along with other diagnostic tests and analysis so as to arrive at a provisional or more complete diagnosis. No surgical procedure should be based on breast thermal imaging alone. Procedures such as mammography, ultrasound, MRI, palpation, biopsy, etc., are needed to arrive at a final diagnosis. Thermography does not "see" inside the body, but shows heat imbalances in the body that may be caused by many things from cancer to inflammation.

We provide only the thermographic component of a complete breast evaluation. Thermography does not replace mammography.

I understand that I will be disrobed relevant to the area of study to allow the surface of my body to cool to an ambient room temperature. I will then be examined with an electronic thermographic camera. I understand this procedure does not use radiation, compression, and that it is not harmful to me. I understand that this procedure's sole function is to map the heat patterns coming from my breast/body.

I understand that it is my responsibility to provide my health care provider with my report for further diagnosis and analysis in the overall evaluation of my health. I have been given a patient preparation form to insure the most accurate thermographic evaluation possible, and I agree that I have completed the requirements of this form and that I have complied with the protocol sheet attached regarding the pre-examination requirements.

Your test will be interpreted by a Board Qualified, or Board Certified Thermologist. It is important to understand that temperature changes can be due to pathological changes as well as artifacts such as rashes, swelling, bruises, and scratching, etc. Your interpretation may require follow-up testing to rule out these issues/ Some pathologic changes may not show up due to their location being too deep within the breast tissue, or overlaying factors. Breast implants can mask thermographic changes secondary to tumor activity. The thermographer will not act as a health care provider, but as a thermography and will report on thermographic findings only.

I am aware that this procedure is not covered by insurance and that the office fee is due and payable at the time of service unless special provisions have been made with the office in advance.

Having understood the above, and having received satisfactory answers to all questions that I may have had concerning the purpose, outcome, benefits and risk factors of thermographic evaluation as well as the utilization of the procedure, I consent to the thermographic examination of my breast/body by the examining doctor(s) and/or technicians.

Patient Signature:_____Date:_____

Printed Name of Patient:_____