

Authorization to Use or Disclose Protected Health Information

Your company name here

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, *Your company name here* 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

Name: _____ Birthdate: _____

Address: _____ City _____ Zip _____

Email: _____ Phone: _____ Doctor: _____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Breast Thermography Confidential Questionnaire

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you have any close relative who has had breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed with breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any biopsies or surgeries to your breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any breast cosmetic surgery or implants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a mammogram in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a mammogram in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had abnormal results from any breast testing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever taken a contraceptive pill for more than 1 year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you suffered with cancer of the womb? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had pharmaceutical hormone replacement therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have an annual physical examination by a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you perform a monthly breast self exam? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. How many mammograms have you had in total? _____ | | |
| 15. What was your age when you had your first mammogram? _____ | | |
| 16. How many births have you had? _____ Your age at birth of first child: _____ | | |
| 17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____ | | |
| 18. Do you smoke? Yes: <input type="checkbox"/> Never: <input type="checkbox"/> Not in last 12 months: <input type="checkbox"/> Not in last 5 years: <input type="checkbox"/> | | |

Have you recently had any of these breast symptoms:	Right Breast.	Left Breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature Today's date _____

Extended Breast Questionnaire

Patient Name: _____ Date: _____

Diagnosed with breast cancer:

Cancer type: Metastatic___ Local___ Lymph node involvement___

When diagnosed: Month___ Year___

Where (left breast): UO___ UI___ LO___ LI___ Nipple___

Where (right breast): UO___ UI___ LO___ LI___ Nipple___

Treatment: Surgery___ Chemo___ Radiation___ Other___ None___

Diagnosed with other breast disease:

Disease type: Fibrocystic___ Cystic___ Mastitis___ Abscess___ Other___
(please report other types of disease in the history)

Breast biopsies or surgery:

Where (left breast): UO___ UI___ LO___ LI___ Nipple___

Where (right breast): UO___ UI___ LO___ LI___ Nipple___

Full Body Study Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name: _____ Birthdate _____

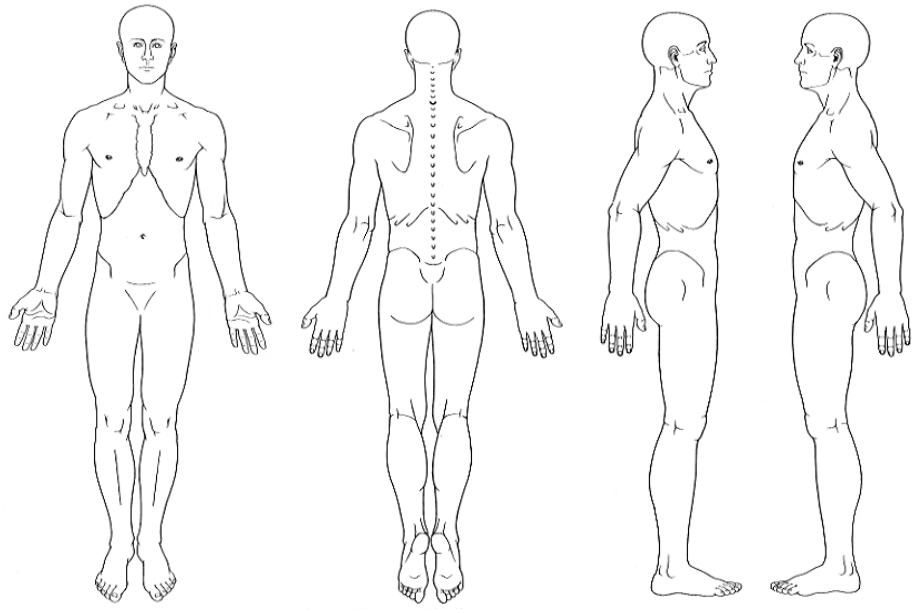
Address: _____

City _____ Zip _____

Phone: _____ Your Doctor: _____

Please Show areas of :

- Main Pain *
- Secondary Pain ○
- Numbness // // // //
- Pins and needles:
- Skin lesions / scaring



- Do you know what triggered the pain ?
- Does anything relieve it ?
- Does anything aggravate it ?
- Has it changed since it began ?
- Have you had any treatment ?

History: Injuries / Fractures / Surgery

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I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature