RADIOLOGY ASSOCIATES
IMAGING

Authorization for the Use or Disclosure of Protected Health Information

RADIOLOGY ASSOCIATES IMAGING
1673 Mason Ave, Suite 104
Daytona Beach, FL 32117
386-274-6172
FAX 386-274-6170

REQUESTING CD & REPORTS of 5 years of BREAST IMAGING

****** MAMMOS, ULTRASOUND, MRI, BIOPSY** (Pathology) & corresponding **paper** **REPORTS******

***Please fax this release & most recent report to confirm receipt of our fax. Notate below date CD to be mailed…*

**** ______________________________ ****
(date CD to be mailed)

I hereby authorize **Radiology Associates Imaging** to use or disclose the Protected Health Information requested above for consultation and/or comparison to BREAST IMAGING exams performed at Radiology Associates Imaging centers:

This authorization is in full force and in effect indefinitely (event that relates to patient or disclosure) at which time this authorization to use or disclose Protected Health Information expires.

I understand that I have the right to revoke this authorization in writing by sending notification to Radiology Associates, **P.A., HIPAA Privacy Officer, P.O. Box 48, Daytona Beach, FL 32115**. I understand when I revoke this authorization, it will not affect any prior use or disclosure of the Protected Health Information by Radiology Associates, P.A.

I understand Protected Health Information released prior to this authorization may be re-disclosed by the party who received that information and may no longer be protected by federal or state law.

Radiology Associates, P.A. will not condition my treatment or payment based on authorization for the requested use or disclosure.

____ ________________________
PRINT *Name of Patient* *Date*

__________________ __________________________ __________________________ ______________________
Date of Birth *last 4 digits of SS #* *patient's phone #* *Appointment Date*

____
(Maiden name) *Please list any other names that may help us locate your records*

____
Signature of Patient or Personal Representative

Revised 9.20.2018

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FACILITY INFORMATION FOR PRIOR MAMMOGRAMS

*Please complete as much information as possible regarding the whereabouts of your prior breast imaging.

** IT IS CRUCIAL FOR US TO OBTAIN ALL PRIOR **BREAST IMAGING** : **MAMMOGRAM**, **ULTRASOUND, MRI BREAST, BREAST BIOPSIES & PATHOLOGIES** TO OPTIMIZE YOUR CARE. **

Name of Imaging Facility: ____

Street Address ____

City ______________________________State _____ ZIP Code ___________

PRIOR FACILITY PHONE NUMBER:_______________________________

PRIOR FACILITY FAX NUMBER:__________________________________

____
List any other names that may help us locate your records (ex. ***Maiden name****)*

********* DATE OF LAST MAMMOGRAM _____________________________

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