RADIOLOGY ASSOCIATES
ORANGE PARK

Mammo Release

Patient ID: _____

Name: _____ DOB: _____

Gender: _____ Referring MD: _____

Exam: _____ DOS: _____

RADIOLOGY ASSOCIATES IMAGING
1673 Mason Ave, Suite 204
Daytona Beach, FL 32117
PHONE 386-274-6172
FAX 386-274-6170

REQUESTING **DICOM CD & REPORTS** of **5 years** of all **BREAST** Imaging:

MAMMOS -ULTRASOUND - MRI Breast -BIOPSY(Pathology) & all printed Reports

**Confirm receipt of fax by faxing reports & date CD will be mailed. **

PowerShare images to:

Radiology Associates Imaging-PCI,DEL,TCI,SAI,TLI,POI

****Please DO NOT send ENCRYPTED CD'S ****

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

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.

_____

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

_____ _____ _____

Signature of Patient or Legal Representative Date SS# (last 4)

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: _____

*********DATE OF LAST MAMMOGRAM: _____