Associates for Women's Medicine

Account #: _____

Today's Date: _____ Patient DOB: _____

Patient Name: _____

I request and authorize my mammography medical records to be released from:

Name/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me to Associates for Women's Medicine.

_____Most recent 4 years of Mammogram Images & Reports Dates: _____

(Images on CD are preferred, however films can be accepted as well)

If you do not have films/CDs or exams on this patient, please call our office.

Records should to be mailed and/or faxed to:

Associates for Women's Medicine
792 North Main Street
STE 200 D
North Syracuse, NY 13212
Phone: 1-315-422-2222
Fax: 877-352-5576

When my information is used of disclosed pursuant to this authorization, it may by Protected Health Information and subject to federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health Care Provider.

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient