RADIOLOGY ASSOCIATES

Authorization for the Use or Disclosure of Protected Health Information

RADIOLOGY ASSOCIATES IMAGING
1673 Mason Ave, Suite 204 • Daytona Beach, FL 32117
Phone: 386-274-6172 • **Fax: 386-274-6170**

PowerShare images to: Radiology Associates Imaging - PCI, DEL, TCI, SAI, TLI, POI

Requesting DICOM CD & REPORTS of 5 Years of Breast Imaging
(MAMMOS, ULTRASOUND, MRI, BIOPSY (Pathology) and corresponding paper reports)

- Do **NOT** send encrypted CDs.
- Please fax this release and 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.

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, LLC, 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, LLC.

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, LLC will not condition my treatment or payment based on authorization for the requested use or disclosure.

NAME OF PATIENT (PRINT)			DATE
DATE OF BIRTH	LAST 4 DIGITS of SS#	PATIENT'S PHONE #	APPOINTMENT DATE
MAIDEN NAME OR ALIAS (Please list any other names that may help us locate your records)			
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE			

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Facility Information for Prior Mammograms

Please complete *as much information as possible* (**in black ink**) 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. Please fax this release form with your most recent report to 386-274-6170.

If you are sending your release via **EMAIL** to **FilmRoom@radassociates.us** please note that we can **ONLY accept scanned documents** (proper formats include: PDF, JPEG, etc.) **Any photographs taken and emailed from a smartphone cannot be accepted** and will cause a delay in retrieving your prior films.

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 (i.e. MAIDEN NAME)		
DATE OF LAST MAMMOGRAM		