RADIOLOGY ASSOCIATES IMAGING

Authorization for the Use or Disclosure of Protected Health Information

Please mail images and fax reports for all prior breast studies to the address & fax # below.

RADIOLOGY ASSOCIATES IMAGING CENTERS

1673 Mason Ave, Suite 104
Daytona Beach, FL 32117
PHONE - 386-274-6172

FAX 386-274-6170

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

ALL MAMMOGRAM & REPORTS
ULTRASOUND Breast & REPORTS
MRI Breast Exams & REPORTS
BIOPSY exams & PATHOLOGY REPORTS.

Please **FAX most current REPORT to confirm receipt of this release & indicate date CD to be mailed (*mailing date*)_____**

MAIL CD in DICOM Format including 5 years of bilateral BREAST 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.

Any FILMS sent will be returned to the facility from which they were requested

_____ _____
PRINT *Name of Patient* *Date*

_____ _____ _____ _____
Date of Birth *last 4 digits of SS #* *patient's phone #* *Appointment Date*

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

_____
Signature of Patient or Personal Representative

Revised 5.23.2018

RADIOLOGY ASSOCIATES IMAGING

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 _____

Revised 5.23.2018