Authorization for REQUEST of Medical Records

____ __________________________

Patient's Name (print) **Date of Birth**

Street Address **City** **State** **Zip Code**

____

Phone Number

I do hereby authorize: ____

Name of Facility

____

Address **City** **State** **Zip Code**

___________________________________ _______________________________

Phone Number **Fax Number**

____ Please mail the (3) most recent years of mammogram studies on a DICOM CD or films with correlating reports to:

The Breast Center of Greensboro Imaging
1002 North Church Street, Suite 401
Greensboro, NC 27401
Attn: Mammogram Dept.

___ Please push the (3) most recent years of mammogram images to The Breast Center of Greensboro/POWERSHARE Canopy and FAX the correlating report(s) to (336) 378-9986

I do hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by this release. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

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Signature of Patient or authorized representative **Date**