IMAGING REQUEST

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that my patient information may be subject to redisclosure by authorized recipients of the information listed below and that my information may no longer be protected by federal privacy regulations once it is disclosed.

Patient Name: _____ D.O.B. ____/____/____ Phone No. ( ) ___ - _____

Persons/entities authorized to user or disclose my patient information:

Facility Name: _____
Address: _____
_____
Phone/Fax: _____

Persons/entities authorized to receive my patient information:

Middletown Medical, P.C.
Mammography Department
111 Maltese Drive
Middletown, N.Y. 10940
845-342-4774 ext.4108
845-342-2520 (fax)

Mammogram and Breast Ultrasound studies - Last 4 studies AND most recent report- CD/DICOM format.
*****<u>If no prior studies on record at your facility please let us know</u> so we do not hold current study unnecessarily. Thank you.**

Specific reason for request: For comparison purposes/continuation of care.

1. This authorization will expire in 6 months.

2. I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, it will not have any effect on any actions the Practice has already taken in reliance on this authorization. Initials: _____

_____ _____
Signature of Patient Date

If this authorization is signed by a patient representative, please complete the following:

Print the name of the patient representative: _____

Describe the representative's authority to act for the patient: _____