Kadlec Advanced Breast Care Center
945 Goethals Drive, Suite 100
Richland, WA 99352
Phone: 509-942-2730 FAX: 509-942-2203

Authorization for Disclosure of Health Information

Request for Mammography Images and Reports
for comparison purposes for the following patient:

Patient Sticker Here

I _________________________________ authorize and request:
Print Name

____
Facility Name:

____
City, State, Zip Code Phone #

To release mammography images and reports to:

KRMC Advanced Breast Care Center
945 Goethals Drive, Suite 100
Richland, WA 99352

Phone# (509)942-2730
FAX# (509)942-2203

PLEASE SEND PREVIOUS TWO YEARS DIGITAL IMAGES ON CD IN DICOM FORMAT IF POSSIBLE.

IF CD NOT AVAILABLE, PLEASE SEND THE PREVIOUS TWO YEARS PRINTED IMAGES AND REPORTS.

Please send information via FedEx using authorization number: 767709-382

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department of Kadlec Regional Medical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 90 days from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Director.

Patient Signature: ________________________________ Date of Birth: __________

Date______________________ Previous Last Name:___________________________

Patient signature authorizes KRMC to receive information requested for comparison purposes.