

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Patient Name:	Patient DOB:
I request and authorize my previous mamm	nography medical records to be released for comparison from:
Name/Facility:	
Address:	
Phone:	Fax:
	th Care Provider to use and/or disclose the following individually Midwest Center for Women's HealthCare.
DIAGNOSTIC MAMMOGRAMS/ULTRASOL	F BREAST IMAGING EXAMS, INCLUDING ANY SCREENING AND JND/PATHOLOGY IMAGES AND REPORTS by VPN, cloud image at. If you do not have breast exams for this patient, please call our
and subject to THE HIPPA Privacy Rule. I he extent that the practice has acted in reliance	ursuant to this authorization, it may be Protected Health Information have the right to revoke this authorization in writing except to the e upon this authorization. My written revocation must be submitted orization shall be in effect until two years from the date of execution
Signed by:	Date:

Records should be mailed and/or faxed to:

Midwest Center for Women's HealthCare Attention: Mammography Dept. 4905 Old Orchard Center Suite 200

Skokie, IL 60077

SKOKIE, IL 600//

Phone: (847) 901-3355 Fax: (888)419-3525