Prior Mammography Imaging Release

Patient's Name: _____

DOB: _____ **Today's Date:** _____

By signing this authorization, I authorize:

_____

Prior Mammogram Facility

("Prior Health Care Provider") to use and/or disclose certain protected health information (PHI) about me to **Optimal Imaging Sacred Heart.**

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me:

_____ Mammography Exams/Reports *(CD Preferred)*

Dates: All Available

The information will be used or disclosed for continuing medical care.

When my information is used or disclosed pursuant to this authorization, it may be Protected Health Information and subject to federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health care provider.

Patient's Signature: _____

Submit to:

☐ **Perdido**
13137 Sorrento Rd., Suite A
Pensacola, FL 32507
(8580) 416-1892 phone
(850) 416-1893 fax

☐ **Tiger Point**
4033 Gulf Breeze Pkwy., Suite A
Gulf Breeze, FL 32563
(850) 416-1894 phone
(850) 416-1895 fax

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