WOMEN'S HEALTHCARE GROUP OF PA
CENTER FOR BREAST HEALTH
4 INDUSTRIAL BLVD, SUITE 130
PAOLI, PA 19301
610-994-1136 phone
215-687-4775 fax

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO WOMEN'S HEALTH CARE GROUP OF PA

By signing this authorization, I authorize _____(**place where prior mammograms were performed**/Prior Health Care Provider) to disclose certain protected health information (PHI) about me to the WHCGPA CENTER FOR BREAST HEALTH.

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed).

_____**X**_____Mammography Exams on CD Dates: All prior mammograms

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 HIPPA 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.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Printed Name Date

_____
Patient's date of Birth

****** The timeliness of interpretation of this patient's upcoming mammogram is dependent on the provision of her previous studies to Center For Breast Health for comparison. We thank you in advance for your attention to the prompt release and delivery of her prior studies to us.**