PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO WENDOVER OB/GYN & INFERTILITY

By signing this authorization, I authorize ____ ("Prior Health Care Provider") to use and/or disclose certain protected health information (PHI) about me to the Mammography Department at Wendover OB/GYN & Infertility.

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). Please send as quickly as possible to the address below, as the patient is awaiting results.

_X_ ALL Mammography Exams/Reports **Dates:** All Available

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

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

Signed by: ____ ___________________________________
Signature of Patient or Guardian Relationship to Patient

____ ___________________________________
Patient's Printed Name Date

____
Patient's Date of Birth

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