Advantage Imaging Solutions

**Attention: Medical Records**
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## Authorization for Use and Disclosure of Patient Health Information

_____ _____ _____
Name of Patient Maiden or Previous Name Date of Birth

_____ _____
Street Address City, State, Zip Code

Phone Number: (Home) _____ (Cell) _____ (Work) _____

| **AUTHORIZE:** | **RELEASE RECORDS TO:** |
|---|---|
| _____ Name of Physician/Healthcare Facility/or Person | _____ Name of Physician/Healthcare Facility/or Person |
| _____ Street Address | _____ Street Address |
| _____ City, State, Zip Code | _____ City, State, Zip Code |
| _____ Telephone # _____ Fax # | _____ Telephone # _____ Fax # |

**RECORDS TO BE RELEASED**:

☐ Mammography Report (Specify Date(s):_____)

☐ Mammography Films (Specify Date(s):_____)

☐ Other:_____

| Reason for Disclosure: | **I would like this information released for the following purpose:** |
|---|---|
| | ☐ Continued care by another provider ☐ Insurance purposes |
| | ☐ Attorney ☐ Other_____ |

I have read and understood the following:

- If I change my mind, I may write to the facility that I have authorized to release my records. This will not apply to records that have already been released.
- There may be a fee for releasing these records.
- Once the records are released, AIS cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.

_____ _____ _____
**Signature of patient or authorized person** **Authorized person's authority to sign** **Date**
(If authorized person is signing, please also print name) (parent, guardian, power of attorney, etc.)

***photo ID required to pick up records/films**

**REASON PATIENT IS UNABLE TO SIGN**: ☐ Minor ☐ Deceased ☐ Other: _____