Advantage Imaging Solutions

Attention: Medical Records
300 Congress Street, Suite 103
Quincy, MA 02169
Phone: (781) 848-0085 Fax: (781) 987-7220

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:

_____
Name of Physician/Healthcare Facility/or Person

_____
Street Address

_____
City, State, Zip Code

_____ _____
Telephone # Fax #

RELEASE RECORDS TO:

Advantage Imaging Solutions
Department of Mammography
300 Congress Street, Suite 103
Quincy, MA 02169
781-848-0085 Fax# 781-987-7220

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: _____