FANNO CREEK CLINIC

AUTHORIZATION FOR RELEASE OF PRIOR IMAGING

PATIENT INFORMATION:

Patient Name _____ Date of Birth ___/___/_____
Previous (Alternate) Names Used in the Past _____

INFORMATION TO BE RELEASED FROM:

Facility Name _____
Facility Address _____ City, State, Zip _____
Phone # _____ Fax # _____

INFORMATION TO BE RELEASED MAILED TO:

Fanno Creek Clinic
Attention: Mammography Department
2400 SW Vermont St.
Portland, Or 97219
Phone: (503) 452-0915 Fax: (503) 768-9232

Please call if patient's films are not available or there are no records for this patient.

INFORMATION TO BE RELEASED:

□ Mammography/3D Tomography Series (past 5 years), Date(s): _____
□ Breast Ultrasound (Reports and Films), Date(s): _____
□ Breast MRI (Reports and Films), Date(s): _____
□ Breast Biopsy Reports, Date(s): _____
□ Other, Date(s): _____
Please send a CD or Thumb Drive in Dicom format or the original analog films with reports.

RIGHTS/AUTHORIZATION:

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that I do not need to sign this form in order to assure treatment or payment. I understand that unless expressly limited by me in writing. I can cancel this authorization at any time by writing to the Privacy Officer at the above-named facility. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws. **This authorization will expire 1 year from the date signed below unless another date or event is entered here** _____

SIGNATURE:

Signature of Patient (or Legal Representative) _____ Date ___/___/_____

Relationship to Patient, if not signed by patient _____