Today’s Date: _____________ Patient DOB: _____________

Patient Name: ____

I request and authorize my mammography medical records to be released for comparison from:

Name/Facility: ____

Address: ____

____

Phone: ________________________________ Fax: ____

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me to **Cornerstone Clinic for Women P.A.**

Please send **MOST RECENT 8 YEARS OF MAMMOGRAM IMAGES AND REPORTS** (VPN or cloud image transmission preferred, CD/ DVD or film also can be accepted)

If you do not have films/CDs or any exams on this patient, please call our office.

When my information is used of disclosed pursuant to this authorization, it may by Protected Health Information and subject to federal HIPAA 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: _________________________________ Date: __________________________________

Records should to be mailed and/or faxed to:

Cornerstone Clinic for Women P.A.
9500 Baptist Health Drive
Suite 100
Little Rock, AR 72205
Phone: 501-217-6658
Fax: 877-464-0229