OBSTETRICS AND GYNECOLOGY ASSOCIATES
A Division Of Women's Care Florida
116 Parsons Park Drive · Brandon, Fl, 33511

AUTHORIZATION FOR RELEASE OF MAMMOGRAM FILMS AND REPORTS TO OBSTETRICS & GYNECOLOGY ASSOC.

Please fill out and sign this form to enable Obstetrics & Gynecology Associates to obtain your prior mammogram films and reports. These will be used for comparison with your new studies.

(Patient Name) (Date of Birth) (Social Security #)

(Complete Address) (Phone)

THE INFORMATION IS TO BE RELEASED BY: **Name of radiology office or hospital where images were taken**	**AND IS TO BE PROVIDED TO:**
Name of Facility	Name of Facility **OBSTETRICS & GYNECOLOGY ASSOCIATES** **MEDICAL RECORDS DEPARTMENT**
Street Address	Street Address **116 PARSONS PARK DRIVE**
City, State and Zip Code	City, State and Zip Code **BRANDON, FL 33511**
Phone # and Fax, if possible	Phone # **(813) 681-6625, EXT 210** Fax **(813) 699-1032**

THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD:

☐ **LAST 2 YEARS OF BREAST IMAGING FILMS ALONG WITH ALL BREAST IMAGING REPORTS AND PATHOLOGY REPORTS YOU HAVE ON FILE.**

********** IF YOU DO NOT HAVE FILMS ON THIS PATIENT PLEASE CALL OUR OFFICE **********

PATIENT—PLEASE BE SURE TO BRING YOUR FILMS WITH YOU TO YOUR APPOINTMENT

I understand that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of signature. I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the healthcare provider or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

Signature of Patient or Person Legally Authorized to Consent for Patient *Date*

Relationship to Patient (if applicable)

A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL