AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

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 **Avina Women's Care.**

Please send **MOST RECENT 8 YEARS OF BREAST IMAGING EXAMS, INCLUDING ANY SCREENING AND DIAGNOSTIC MAMMOGRAMS/ULTRASOUND/PATHOLOGY IMAGES AND REPORTS** by VPN, cloud image transmission, or CD/DVD in DICOM format. *If you do not have breast exams for this patient, please call our office.*

When my information is used or disclosed pursuant to this authorization, it may be Protected Health Information and subject to The 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. This authorization shall be in effect until two years from date of execution at which time this authorization expires.

Signed by: _____ Date: _____

Records should be mailed and/or faxed to:

☐ **Avina Women's Care**
460 Polaris Parkway
Suite 210
Westerville, OH 43082
Phone: (614) 895-8227
Fax: (614) 918-9691

☐ **Avina Women's Care**
5150 Bradenton Ave
Suite A
Dublin, OH 43017
Phone: (614) 792-7797
Fax: (614) 766-1335

☐ **Avina Women's Care**
1315 West Lane Ave
Suite D
Columbus, OH 43221
Phone: (614) 495-9532
Fax: (614) 929-5262