1621 N. MILLS AVENUE (17-92)
ORLANDO, FL 32803

1718 S. ORANGE AVENUE
ORLANDO, FL 32806

(407) 841-0822
(800) 367-1870
(407) 841-0411 fax
wcrorlando.com

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REGARDING MEDICAL RECORDS

The enclosed films are the property of Women's Center for Radiology, P.A. as specified by Florida State Law, 455.667, and must be maintained for a minimum of seven years.

By signing this authorization, I authorize Women's Center for Radiology to use and/or disclose certain protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

This authorization permits Women's Center for Radiology to use or disclose the following individually identifiable health information (specifically describe the information to be released, such as date(s) or service, level of detail to be released, origin of information, etc.)

With my consent, Women's Center for Radiology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory results among others. Women's Center for Radiology may also mail to my home or designated location any items that assist the practice in carrying out TPO such as reminder cards and patient statements.

Women's Center for Radiology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Womenís Center for Radiology, 1621 N. Mills Ave., Orlando, Florida 32803.

When my information is used or disclosed pursuant to this authorization, it may be subjected to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Women's Center for Radiology has acted in reliance upon his authorization. My written revocation must be submitted to Women's Center for Radiology at 1621 N. Mills Ave., Orlando, Florida 32803 or your may fax your request to (407) 841-0411.

ORDERING PHYSICIAN/FACILITY ____

SIGNATURE ____ DATE ________________

PRINT NAME ____

ACR Accredited Breast Center of Excellence

W74460 (08/08)