



Lake Medical Imaging & Vascular Institute

Patient Authorization for Use and Disclosure Of Protected Health Information - Mammography

Please complete and sign this form and mail it to the location of your prior mammogram.
Once the films are in your hands, please contact us to schedule your mammogram appointment.

Note to our valuable patient:

It is very important that you try to obtain your prior mammogram. Having prior films available when you come in for your mammogram allows the radiologist to compare all films (new and old). This will allow the radiologist to note any changes seen.

____ Please send the mammogram and a copy of the report to the patient at this address:

____ Please send the mammogram and a copy of the report to:

LAKE MEDICAL IMAGING
801 East Dixie Ave, Suite 104
Leesburg, FL 34748
352-787-5858

The information will be used or disclosed for the following purpose:

Comparison and/or Radiological Medical Imaging Evaluating.

This authorization remains effective for one year from the date signed.

I do not have to sign this authorization as a condition for receiving treatment from Lake Medical Imaging and Vascular Institute.

When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal 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 Privacy/Compliance Officer at:

Janice Blakeley, Privacy/Compliance Officer
Lake Medical Imaging & Vascular Institute
801 E. Dixie Ave., Suite 104
Leesburg, FL 34748

I authorize _____ to release my mammography films and reports.

Address & Phone Number of Authorized Facility _____

Patient Signature

Print Patient Name

Patient Date of Birth

Daytime phone number

or Personal Representative/Guardian Signature

Print Personal Representative/Guardian Name

Relationship to Patient

Witness Signature

Print Witness Name

Date Signed