FLORIDA HOSPITAL
WATERMAN
Digital Mammography

Consent for Release of Medical Information

PATIENT NAME	**PHONE #**
PATIENT NAME ON PRIOR FILMS (if different from above)	
DATE OF BIRTH	**SSN**
MEDICAL RECORD #	

The following organization is authorized to make disclosure of my Mammography Reports and/or Images:

FACILITY NAME	**PHONE #**
ADDRESS	
STATE	**ZIP**

This information may be disclosed to and used by:

FLORIDA HOSPITAL WATERMAN

Attention: Mammography Department

1000 Waterman Way • Tavares, FL 32778

Phone (352) 253-3394 • Fax (352) 253-3423

Please send REPORTS and DIGITAL MAMMOGRAPHY IMAGES on CD or ANALOG HARD COPY FILMS

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department / Medical Record Staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 6 months): _____. If I fail to specify an expiration date, event or condition, this authorization will expire 6 months from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

Signature of Patient _____ Printed Name of Patient _____ Date _____

Contact 352.253.3941 for reorder
Revised 09/2011

IHRLSINFO

AFFIX PATIENT LABEL HERE