



THE ELIZABETH WENDE BREAST CLINIC

WENDE W. LOGAN-YOUNG, M.D. / STAMATIA DESTOUNIS, M.D. / ERMELINDA BONACCIO, M.D. / MARGARITA ZULEY, M.D.
SUSAN ROUX, M.D. / LARI SCORZA, M.D. / POSY SEIFERT, D.O. / PATRICIA SOMERVILLE, M.D.
170 SAWGRASS DRIVE / ROCHESTER, NEW YORK 14620
TELEPHONE 585-442-2190 FAX 585-442-1837 www.ewbc.com
PRACTICE LIMITED TO MAMMOGRAPHY, ULTRASONOGRAPHY, DUCTOGRAPHY,
CYST ASPIRATIONS & NEEDLE ASPIRATION CYTOLOGY, CORE BIOPSY, BONE DENSITOMETRY



**CONSENT TO THE USE AND DISCLOSURE OF HEALTHCARE INFORMATION
RECEIPT OF PRIVACY STATEMENT**

I hereby authorize THE ELIZABETH WENDE BREAST CLINIC to obtain
prior mammogram films, breast ultrasounds, and medical reports on:

LAST NAME _____ FIRST NAME _____

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

PLEASE SEND: MAMMOGRAMS FILMS BREAST ULTRASOUNDS MEDICAL REPORTS

OTHER INFORMATION (please specify) _____

Please send to: ELIZABETH WENDE BREAST CLINIC
170 Sawgrass Drive
Rochester, NY 14620

I understand that as part of my healthcare, The Elizabeth Wendé Breast Clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- ¥ A basis for planning my care and treatment.
- ¥ A means of communications among the healthcare professionals who contribute to my care.
- ¥ A source for billing and payment by third party payors.

I authorize the release of my present and prior medical records pertaining to mammograms, breast ultrasound, breast biopsy and lab results to the Elizabeth Wendé Breast Clinic. I also authorize the Elizabeth Wendé Breast Clinic to release all present and prior medical records to other physicians, specialists or health care providers involved in my health care. The Elizabeth Wendé Breast Clinic has my authorization to release my present and prior medical records to my insurance company or companies to make a complete diagnosis and to process my insurance claim.

I authorize payment of medical benefits to the Elizabeth Wendé Breast Clinic.

I understand that I am responsible for reimbursing the Elizabeth Wendé Breast Clinic for financial charges that are not covered by my insurance.

I acknowledge that I received a copy of the Elizabeth Wendé Breast Clinic's Notice of Privacy Procedures.

Patients Signature _____ Date ____ / ____ / ____