Elizabeth Wende Breast Care, LLC
170 Sawgrass Dr. / Rochester, NY 14620

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

I hereby authorize Elizabeth Wende Breast Care, LLC to obtain prior mammogram films, breast ultrasounds and medical reports on:

LAST NAME: ____ FIRST NAME: ______________________________

Date of Birth: _____ /_____ /_____ Last 4 Digits of Social Security # X X X - X X - ___ ___ ___ ___

I understand that as part of my healthcare, Elizabeth Wende Breast Care, LLC originates and maintains health records describing my health history, symptoms, examinations 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 payers.

I authorize the release of my present and prior medical records pertaining to mammograms, breast ultrasound, breast biopsy and lab results to Elizabeth Wende Breast Care, LLC. I also authorize Elizabeth Wende Breast Care, LLC to release all present and prior medical records to other physicians, specialists or healthcare providers involved in my healthcare, and to release my present and prior medical records to my insurance company or companies to facilitate payment.

I authorize Elizabeth Wende Breast Care, LLC to use my de-identified x-ray images and information for educational and research purposes.

I understand that separate signed consent forms would be required by the FDA for research projects that meet specific detailed criteria to ensure the privacy of my PHI, as established by the HIPAA Privacy rule.

We may provide your name and address to our affiliate, Rejuvenate at Elizabeth Wende, LLC so that they may mail marketing materials to you about their services.

I authorize payment of medical benefits to Elizabeth Wende Breast Care, LLC.

I understand that I am responsible for reimbursing Elizabeth Wende Breast Care, LLC for financial charges that are not covered by my insurance. Depending upon my insurance carrier, if I need to have additional x-rays or tests, there may be an additional out-of-pocket charge or co-pay assessed.

I acknowledge that a copy of Elizabeth Wende Breast Care, LLC's Notice of Privacy Procedures is available at the reception desk.

Patient Signature: ____ Date: _____ /_____ /_____

FOR OFFICE USE ONLY

PLEASE SEND: ☐ MAMMOGRAMS ☐ FILMS ☐ BREAST ULTRASOUNDS ☐ MEDICAL REPORTS

OTHER INFORMATION (please specify): ____

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