MAIN OFFICE: 170 Sawgrass Drive | Rochester, NY 14620
Phone: 585-442-7955 Fax 585-758-7096

MEDICAL RECORDS DEPARTMENT

AUTHORIZATION TO USE OR DISCLOSE MEDICAL INFORMATION

MEDICAL INFORMATION RELEASE FORM

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

LAST NAME ____________________________ FIRST NAME ________________________

Appointment date ___ /___ /___ Date of birth ___ /___ /___

Send all specified records/images to:
Medical Records Department
Elizabeth Wende Breast Care
170 Sawgrass Drive | Rochester, NY 14620

I understand that my consent to release/obtain information will expire one year from the date of my signature.
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 understand that I have the right:

- To object to the use of my health information for directory purposes
- To request restrictions as to how my health information may be used or disclosed to insure treatment, payment or healthcare operations and that Elizabeth Wende Breast Care is not required to agree to the restrictions requested
- To revoke this consent in writing

Elizabeth Wende Breast Care will not condition my treatment on whether I sign this authorization.

Patient's Signature ________________________ Date___ /___ /___

Revised: ________________________ Date: ___ /___ /___