Elizabeth Wende Breast Care
Breast Imaging Excellence

Stamatia Destounis, M.D., FACR | Posy Seifert, D.O. | Philip F. Murphy, M.D. | Wade Hedegard, M.D.
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To comply with the HIPAA laws regarding patient confidentiality, we request a signed authorization from you to release your prior images and reports. If you have any questions, we can be reached at (585) 442-7955.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize Elizabeth Wende Breast Care to release prior imaging, and medical reports on:
Patient's Name: _____ Date of Birth: _____

Send all specified records/films to:
Facility/Name: _____
Address: _____
_____

Please specify which records you would like sent. Please write "all records" if you are requesting your entire medical record. Genetics records will require a separate disclosure.

_____
_____
_____

Please list any prior names you have gone by: _____
_____
_____

I understand that my consent to release information will expire one year from the date of my signature.

I understand that I have the right to revoke this consent in writing at any time.

Patient's Signature: _____ Date: _____