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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: \_\_\_\_\_

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