Account #: ___________________

Today's Date: ________________ DOB: _________

Name: ____________________________________

Patient Authorization for use and disclosure of protected health information to Fort Sanders OB/GYN Group P.C.

By signing this authorization, I authorize _____________________________________ (Prior Health Care Provider) to use and/or disclose certain protected health information (PHI) about me to the Mammography Department at Fort Sanders OB/GYN Group P.C..

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed).

_________ Mammogram Films & Reports _________ Dates: __________________

_________ Mammography Exams on CD _________ Dates: __________________

If you do not have films/CDs or exams on this patient, please call our office at: 865-524-3208

The information will be used or disclosed for continuing medical care. This authorization will expire 30 days from the date that I sign this form. Date of signature: _____________

When my information is used or disclosed pursuant to this authorization, it may be Protected Health Information and subject to federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health Care Provider.

Signed by: _________________________________ ___________________________

Signature of Patient or Legal Guardian — Relationship to Patient

_________________________________ ___________________________

Patient's Printed Name — Date

____

Patient's Date of Birth

Fort Sanders OB/GYN Group P.C.
501 19th Street Suite 509
Knoxville, TN 37912
Tel: 865-524-3208
Fax: 865- 522-4322