Piedmont HEALTHCARE

Authorization for Use/ Disclosure of Protected Health Information

Breast Imaging Release

Patient Label

The form below authorizes Piedmont Healthcare to request prior mammogram records, including mammogram and breast ultrasound images and results, from other healthcare entities on behalf of the patient.

PATIENT INFORMATION: The following information is needed to assist the provider in locating the patient's medical record.		
Patient Name:	Maiden or Other Names:	
Patient Address:	Date of Birth:	Phone:
City/State/Zip:	Email:	Cell/Alternate #:

REQUEST AUTHORIZATION of RECORDS: I hereby authorize the facility below to disclose all prior mammography images and results as well as any associated breast ultrasound images and results, including the most recent mammogram/breast ultrasound records.	
Facility Name:	
Facility Street Address:	Facility Phone:
Facility City/State/Zip:	
Date(s) of Prior Mammogram(s):	

DISCLOSURE: Records are to be disclosed to the below Piedmont Healthcare location. Please list the location information below, at which you are having your upcoming mammogram.	
Piedmont Facility Name:	
Piedmont Facility Address:	City/State/Zip:
***Administrative Note:** Preferred method of image delivery is via PowerShare.*	

AUTHORIZATION for USE/DISCLOSURE of PROTECTED HEALTH INFORMATION
I understand that the information that I am authorizing the above designated provider to use/disclose may include information related to the patient's medical history, diagnosis or treatment of the patient, including genetic testing or information derived from genetic testing. I hereby waive any privilege concerning such information for the disclosure to the person or entity I have authorized above. I understand that the information used/disclosed pursuant to this authorization will not include psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing contents of conversation during a counseling session that are kept separate from the rest of the medical record.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations.
I understand that unless otherwise limited by state or federal regulations, I may revoke this authorization at any time by presenting my revocation in writing to the entity designated above that was previously authorized to release, except to the extent that such entity has taken action in reliance on this authorization. I understand that a revocation form may be obtained from the Piedmont Healthcare entity indicated above.
I understand that this authorization is specific to the information, purpose and date(s) of services indicated above. I further understand that this authorization is valid for 365 days from today's date and will expire at that time unless another date is written here →:
Lastly, I understand that Piedmont Providers shall not condition treatment on the receipt of this authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party.
Note: There may be fees for provision of the information requested; however, records for treatment purposes may be faxed to the patient's healthcare provider when requested at no charge. Under most circumstances, applicable law permits up to thirty (30) days for record requests to be processed.

Patient or Legal Representative Signature	Please PRINT Name	Today's Date	Time

As Legal Representative, my relationship to the patient is:_____. Any document proving such authority must be attached.

The patient is unable to sign because:_____

Location Fax Information

Patients, please fax this completed form to the location of your upcoming appointment.

Location	Fax Number
Doris Shaheen Breast Health Center at Piedmont Atlanta	404-367-7338
Piedmont Imaging at Brookhaven	404-367-7338
Piedmont Imaging at Kennesaw	404-367-7338
Piedmont Imaging at Piedmont West	404-367-7338
Oconee Health Campus Women's Center Breast Imaging	706-552-1829
Piedmont Athens Regional Breast Health Center	706-475-5979
Piedmont Athens Regional Royston Health Campus	706-475-2165
Piedmont Columbus Regional Breast Care – Midtown	706-660-6438
Piedmont Fayette Women's Imaging Center	770-719-6611
Piedmont Henry Breast Health Center	678-289-9706
Piedmont Mountainside Hospital	706-301-5405
Piedmont Mountainside Hospital Outpatient Diagnostic Center	706-301-5405
Piedmont Mountainside Outpatient Imaging Center	706-301-5405
Piedmont Newnan Faye Hendrix-Ware Breast Health Center	770-254-3266
Piedmont Newnan Outpatient Center	770-254-3266
Piedmont Newton Hospital Women's Diagnostic Center	770-385-4533
Piedmont Rockdale Women's Diagnostic Center	770-918-3738
Piedmont Walton Imaging Center	770-267-1713