Patient Instructions: Fax or Mail This Completed Form to Catawba Women's Center

PO Box 38
Hickory, NC 28603-0038

Fax: 828-322-3767

You need NOT submit this form to us in advance if ALL of your previous mammogram studies were at Catawba Valley Imaging Center.

CATAWBA WOMEN'S CENTER
Caring For A Lifetime

Release of Mammogram/Health Record Information

Catawba Women's Center, P.A.
Attention: Medical Records **Phone: 828-322-4140**
PO Box 38 **Fax: 828-322-3767**
Hickory, NC 28603-0038

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CATAWBA WOMEN'S CENTER

Patient Name _____ Social Security # _____ Date of Birth _____

Previous name(s) (if applicable): _____

By signing this authorization, I authorize *(check one below or specify the name of previous provider)*

☐ FryeCare	☐ Catawba Valley Imaging Center* *You Need NOT submit this form in advance if ALL of your Previous Screening Mammograms were at Catawba Valley	☐ Other / **Please Specify:**

(Prior Health Care Provider/Mammography Provider)

to use and/or disclose certain protected health information (PHI) about me to the Mammography Department at Catawba Women's Center, Hickory, North Carolina.

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).

☑ Mammography Films & Reports (Exams are preferred on CD if possible) — (2007 - Present) Exam Dates/Years

If you do not have films/CDs or exams for this patient, please call our office at 828-322-4140.

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

When my health 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.

Signature of patient or *patient's representative** _____ Date _____

**Printed name of patient's representative, if applicable* _____ *Representative's authority* _____