FACILITY: _____CITY: _____ STATE: _____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birthdate: _____
Address: _____ SS #: _____
_____ MR#/Acct#: _____

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature.

PLEASE SEND THE FOLLOWING FROM LAST FIVE YEARS (*if that many available*) TO PRESENT:

___ MAMMOGRAM IMAGES (ON CD) AND REPORTS

___ BREAST ULTRASOUND IMAGES (ON CD) AND REPORTS

___ BREAST MRI IMAGES (ON CD) AND REPORTS

___ BREAST BIOPSY IMAGES (ON CD) AND REPORTS

I understand that the information in my health record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

The disclosed information is to be used by the following individual organization for the purpose of:
☑ Continued Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other
*(specify)*_____

NAME, ORGANIZATION: SHENANDOAH MEMORIAL HOSPITAL MEDICAL IMAGING
ADDRESS: 759 MAIN ST., WOODSTOCK, VIRGINIA 22664
PHONE/FAX: P. 540-459-1207 F. 540-459-1205

I understand this consent is voluntary and that I have a right to revoke this authorization at any time, except to the extent that action based on this consent has already been taken. I understand that if I revoke this authorization I must do so by written, dated, and signed communication to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact the Health Information Management Director at 540-459-1195.

_____ _____
Signature of Patient or Legal Representative Date signed