BREAST CENTER
of ACADIANA

Authorization to Share Protected Health Information

By signing below, I hereby authorize the RELEASE of all of my current and future breast imaging records to Breast Center of Acadiana to include: film, CD, surgery, pathology and final reports. Should I need my imaging records sent to another facility for treatment purposes, I give Breast Center of Acadiana my permission to release my records to include: film, CD, pathology and final reports. **This authorization will expire 3 years from the date of signature, unless revoked in writing by the Patient/Personal Representative before that date.**

Patient Name: _____ DOB: _____

Facility: _____ Date/Year of Mammogram: _____

Facility: _____ Date/Year of Mammogram: _____

Imaging records should be sent to:

Breast Center of Acadiana

107 Centre Sarcelle Blvd., Suite 701

Youngsville, LA 70592

Phone: (337) 504-5000 Fax: (337) 408-3921

_____ _____

Signature of Patient/Personal Representative **Date**

_____

Printed Name of Patient/Personal Representative