

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any previous names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release protected healthcare information of the patient’s name above to:

**River City Imaging Centers**

**ATTN: Medical Records**

**1750 E. Common St, Suite 1101**

**New Braunfels, TX, 78130**

**Phone: 830-302-4355**

**Fax: 830-312-7677**

This request and authorization apply to the following:

**Mammogram Images and reports- ALL PRIORS**

**Ultrasound images and reports**

**Pathology reports**

**MRI Images and reports**

**CT Images and reports**

I am aware I have the right to revoke this authorization at any time, provided that I give reason in writing to River City Imaging Centers. If I revoke this authorization, I understand River City Imaging Centers will no longer use or disclose information with the authorized person stated above. I also understand, River City Imaging Centers cannot retrieve any disclosures already made with my permission. (DISCLAIMER: River City Imaging Centers adheres to the CMS HIPAA guidelines; Pursuant to Section 45 CFR 164.502(g))

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note to patient:** For screening mammograms- if your prior mammograms do not arrive in 14 business days then your mammogram will be dictated at that time without comparison.

Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_