St. Anthony Breast Center
St. Anthony Hospital
Medical Plaza 2, Suite 100
11700 W. 2nd Place
Lakewood, CO 80228
720-321-8230

St. Anthony Hospital
Centura Health

If you have had a mammogram/ultrasound and or breast MRI at another facility please complete and sign this authorization requesting your prior films be sent to the St. Anthony Breast Center. Please fax the form to 720-321-8231.

Patient Name: _____ DOB _____ Last 4 digits of SS# _____

Phone: (home) _____ (cell) _____ (work) _____

Medical Information Requested from: _____

Location where prior mammo performed (address): _____

_____

Information Requested: Images and reports for the following examinations & dates

_____ Breast Ultrasound: Dates: _____

_____ Mammogram: Dates: _____

_____ Breast MRI: Dates: _____

Other: Dates: _____

Purpose of disclosure / why information requested: Comparison / Treatment

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This Authorization expires 180 days (6 months) from the date of signing.** A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand that there may be a charge for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form upon request. If I have questions about disclosure of my health information, I can contact the facility Privacy Officer or their designee.

I request that the health information indicated above be sent to St. Anthony Breast Center, Medical Plaza 2, Suite 100, 11700 W. 2nd Place, Lakewood, CO 80228.

Signature: _____ **Date:** _____ **Time:** _____
Patient, Parent or Guardian if patient is a minor

If patient is unable to sign, please document reason: _____

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

Relation (if other than patient) _____

Driver's License #: _____ Other ID# _____