Bonita Community Health Center
3501 Health Center Boulevard
Bonita Springs, FL 34135
(239) 949-6105

RADIOLOGY RELEASE OF INFORMATION

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize

_____

Name of facility where **previous** studies are located

_____

(City, State, Zip) Phone Number Fax Number

To release information from the health records of:

PATIENT: _____ **DOB:** _____

PHONE: _____

Information to be disclosed:

____ **Previous Mammograms & Reports** (2 YEARS ON CD IF POSSIBLE) **Permanent Transfer** _____

____ Other _____

This information is to be disclosed to:

Bonita Community Health Center
Atten: Radiology Department
3501 Health Center Blvd
Bonita Springs, FL 34135

Phone (239) 949-6105 Fax (239) 949-6175 for the purpose of comparison.

According to the Privacy Notice, I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire in 90 days. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Patient/Guarantor's Signature Date

_____ _____
Witness Date

1360/02 rev 11/17