Mammography Department

Authorization for release of all breast related images, INCLUDING reports to be used for comparison in treatment or consultation of care.

Patient Name: _____ DOB: _____

Previous name(s) (maiden or other): _____

Approximate date of last breast procedure: _____

Name of Facility: _____

Address: _____

City/ State/ Zip: _____/ _____/ _____

Phone: _____

Fax: _____

Please send Dicom CDs or Analog/ Original Film & Copies of Reports to:

The Women's Clinic of Northern Colorado
1107 S. Lemay Avenue, Suite 300
Fort Collins, CO 80524
Phone: 970-294-4463 Fax: 970-493-2990
www.fcwc.com

*It is important that we receive the patient's films as soon as possible so that the current study can be interpreted.
If you do NOT have images for this patient please notify our office as soon as possible
970-294-4463

Studies will be returned to your facility within thirty (30) days of the patient's exam. We are no longer able to permanently retain prior breast imaging from other facilities.
Thank You.

Patient/ Authorized Representative
Signature: _____ Date: _____

Patient Phone #: _____

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Office at The Women's Clinic of Northern Colorado, 1107 S Lemay Ave, Ste 300, Fort Collins, CO 80524. Unless revoked, this authorization will expire in 90 days from the date of signature. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Reliability Act of 1996. 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.
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed. I authorize The Women's Clinic of Northern Colorado to use and/or disclose the protected health information specified above.