BREAST CENTER
of ACADIANA

PRIVACY & DISCLOSURE ACKNOWLEDGEMENT

Authorization to Release 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, I give Breast Center of Acadiana my permission to release my records to include: film, CD, pathology and final reports. Your imaging records can be obtained from the facility/facilities where your breast imaging, surgery and/or pathology was performed.

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) 456-9773

Acknowledgement Receipt of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Breast Center of Acadiana, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

_____ _____

Signature of Patient/Patient's Representative Date

_____

Printed Name of Patient/Patient's Representative