Lakeview Clinic

Mammography

Release of Protected Health Information

*ONE PATIENT PER FORM

1. Patient Information: *This information is used to identify your health information and ensure only your information is sent.*

Patient Legal Name: _____ Birth date: _____

Mailing address: _____

Previous Name(s): _____

Phone numbers (Mobile): _____-_____-_____ (Home): _____-_____-_____ (Other): _____-_____-_____

2. I am requesting health information be released **from** at least one of the following (check **one** option):	3. I am requesting health information be **sent** to:
Hospital/Clinic/Provider: (name): _____ (location) _____ (fax number) _____	Lakeview Clinic, Ltd. Attention: Mammography 424 State Hwy 5 West Waconia, MN 55387 Fax: (952)442-5751

4. Information to be released: *IMPORTANT: Indicate only the information you authorize to be released.*

Specific dates/years of treatment: _____

☐ Three most recent mammograms and/or breast ultrasounds with reports faxed.

5. Preferred method of image transfer

☐ Please push images to Lakeview Clinic

☐ Please push images to Ridgeview Medical Center (RMC)

☐ Mail CD

Nuance Powershare Available, Lakeview Clinic, Ltd.
InteleShare/Ambra Share code: LVC_080625
Medicom downloads accepted-fax to 952-442-5751

6. Reason(s) for releasing information:

☐ Continuation of Care

☐ Other (please explain): _____

Consent & Expiration:

- By signing this form, I request that the health information specified in section 4 be sent to the third party named in section 3.
- I may stop this consent at any time by writing to the organization(s) and or professionals named in section 3.
- If the organization or professional named in section 3 has already released health information based on my consent, my request to stop will not apply to the released information.
- I understand that the health information specified in section 4 is sent to the third party named in section 3; the information could be re-disclosed by the receiving third party and it may no longer be protected by federal or state privacy laws.
- I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event below.

End Date of Consent: _____ OR specified event: _____

Patient Signature _____ Date: _____

OR legally authorized representative's signature_____ Date: _____

Representative's relationship to the patient: _____

- If the representative is not the parent of a child under 18, please ensure Lakeview Clinic has a copy of legal guardianship documents on file.

For questions about this form, please call (952)442-4461 and request radiology.