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

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.

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.