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Phone: 606-219-4184
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CT Scans ∗ Full Body Ultrasound ∗ Bone Density (DEXA) Scans ∗ Breast Imaging

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

DOB: _____ SS# _____

I hereby authorize Kentucky Breast Care to use/disclose my Individually Identifiable Health Information In the manner described within this authorization. I understand that this authorization Is voluntary and that If the parson or entity authorized by this document Is not a health plan or health-care provider that my Information may no longer be protect from further disclosure by state or federal law. I understand this release permanently transfers my records to K.B.C.

Have you had any of the following BREAST IMAGING performed?

Previous mammogram(s) _____
Breast ultrasound(s) _____
Breast MRI(s) _____
Breast Tomography (3D mammography) _____
If any of these are yes, where are these priors located?
Facility: _____ City: _____State: _____
This also includes any other imaging studies or path reports needed to aid the radiologist in the diagnosis or manage of breast health or disease.

Have you had any of the following BODY IMAGING performed?

CT's? _____ If so, of what? _____
Body Ultrasounds? _____ If so, of what? _____
If any of these are yes, where are these priors located?
Facility: _____ City: _____State: _____

Patient Consent:
I understand that my healthcare will not be affected if I do not sign this form. I understand that i may revoke this authorization at any time by notifying Kentucky Breast Care in writing, except to the extent that has already taken in reliance to the previous authorization period. I understand that I have the right to receive a copy of this information, if I request it.
I hereby authorize the use or disclosure of mv individually identifiable health Information described above. I understand that unless restricted by individual state laws, that this Information may contain Information about HIV, AIDS, Venereal disease or mental health disorders. I understand that the exception to this authorization applies to (In accordance with CFR part 2) records containing drug/alcohol abuse or therapist psychiatric notes. These record types require a separate authorization and are not Included In this consented release of Information.

_____ _____
Signature of Patient or Patient Representative Date

For Fastest Results…Before your appointment, please Drop-off ALL Prior Imaging Disks & Reports to:

KBC / Somerset Family Imaging
100 Sarahs Ln, Somerset, KY 42503
Fax: 606-678-8368

Locations:
100 Sarahs Ln, Somerset, KY 42501
38 Dr. Joe T. Pettey Dr., Russell Springs, KY 42642

www.SomersetFamilyImaging.com
www.KentuckyBreastCare.com