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CT Scans * Full Body Ultrasound * Bone Density (DEXA) Scans * Breast Imaging

Authorization for Release of Information
PRIOR BREAST SONOGRAMS

MRN:_____

IF: You only have prior ultrasound images (because you were under the age of 30 and never had a Mammogram)… THEN: KBC would like to review your prior Sonograms.

Patient: Please fill out the *Italicized* portions, so we can obtain your prior images/reports.

Full Name (First, Middle, Last): _____

Any other prior names: _____

DOB: _____ *SSN#:* _____

Facility: Please send prior Reports & Images (Breast Ultrasound) to: Kentucky Breast Care
Where have you had prior Breast Sonograms? Please list ALL locations during past 10 years

Facility Name: _____ *City:* _____ *State:* _____

Facility Name: _____ *City:* _____ *State:* _____

Patient Consent:
I hereby authorize Kentucky Breast Care and Somerset Family Imaging to use or disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorization 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 Kentucky Breast Care and Somerset Family Imaging.

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 and Somerset Family Imaging in writing, except to the extent that has already been 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 my 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 expectation to this authorization applies to (in accordance with CFR part 2) records containing drug or 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 return this signed release to us, OR Drop off / Mail ALL Prior Imaging Disks & Reports to:

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