

**AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION**

**TO:** \_\_\_\_\_

**Address** \_\_\_\_\_

**City, State Zip Code** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

I hereby request that my Private Health Information be released to:

**The Breast Center**  
**55 Sunbridge**  
**Fayetteville, AR 72701**  
**479-442-6266 phone 479-521-3877 fax**

**Specific information to be released to the above referenced entity:**  
**PLEASE SEND ALL BREAST IMAGING REPORTS, FILMS AND ANY**  
**PATHOLOGY FOR THE LAST TWO EXAMS OR LAST TWO YEARS DONE**  
**AT YOUR FACILITY**

This Authorization shall be deemed to expire on the earlier of one (1) year from the date set forth next to my signature or within reasonable time following completion of the event which gave rise to the purpose of this Authorization.

I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by delivering a revocation in writing to the Clinic.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic.

The Clinic has informed me that the Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on obtaining this authorization.

I understand that I may refuse to sign this Authorization.

**Patient name (print):** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient. \_\_\_\_\_

**The Breast Center of Northwest Arkansas, 237 East Millsap Rd, Ste 8, Fayetteville, AR 72703 Phone (479) 442-6266 Fax (479) 521-3877**