



For Nuance PowerShare image transfer send to The Women's Center of Orlando (Spoke)



If mailing DVD send to below address

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____

Previous Name: _____

I request and authorize _____ to release healthcare information of the patient named above to: _____ (Name of Imaging Facility)Address,

The Women's Center of Orlando
2914 17th Street
St. Cloud, FL 34769

PLEASE FAX REPORTS TO: 407-857-1855

The request and authorization apply to:

All Breast Imaging and Reports (Mammography and Ultrasound)

Patient Signature: _____

Date Signed: _____

AS NOTED IN THE HIPAA REGULATIONS:

“Section 164.506 of the HIPAA privacy regulations permit release of information for treatment, payment, or healthcare operation purposes without a specific patient authorization. Consequently, the regulation allows a mammography facility to transfer medical records to another covered entity in most situations without specific patient authorization. The Office of the Civil Rights, the KHHS office with primary responsibility for HIPAA implementation, has also stated that, a covered healthcare provider may share protected health information with another health care provider for the treatment purposes without a business associate contract.”