M·U·S·I·C
Mammography & UltraSound
Imaging Center, PLLC

John M. Elliott, M.D.

Judy M. Yancey, M.D.

Release of Records Authorization

Consent to use, obtain, and disclose protected health information

MRN: _____ Appt Date: _____ Appt Time: _____

Patient Name: _____ DOB: _____ SSN: _____

I, _____, hereby give my permission to Mammography and Ultrasound Imaging Center, PLLC to obtain my protected health information from others for the purpose of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I hereby give my permission to Mammography and Ultrasound Imaging Center, PLLC to use and disclose my protected health information disclosed by another covered entity for the purposes of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

This release covers all my personal health information including but not limited to medical reports, progress notes, CDs, films, diagnostic studies, lab work, and any other documentation requested by Mammography and Ultrasound Imaging Center, PLLC for the purposes of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I understand that Mammography and Ultrasound Imaging Center, PLLC may request this information from health care providers, hospitals, ancillary service providers, and other entities. I understand that Mammography and Ultrasound Imaging Center, PLLC will use my personal health information solely for the purposes of treatment, obtaining payment, and supporting the day-today operations of the practice.

A copy of this release is as valid as the original. This is a lifetime release unless revoked by me in writing.

Facility Name: _____

Facility City/State: _____

Type of records: _____

Name of Person Signing Below: _____

Relationship to Patient: _____

Signature of Patient or Parent/Guardian: _____Date:_____