EPIC HEALTH
www.epichs.org

MAMMOGRAPHY PRIOR RELEASE

18591 W. 10 Mile Rd., Southfield, MI 48075
Phone: 248.621.9443 Fax: 248.416.1355

TODAYS DATE _____

PATIENT DOB _____

PATIENT NAME _____

I request and authorize my mammography medical records to be released for comparison from:

NAME/FACILITY _____

ADDRESS _____

PHONE _____

FAX _____

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me to Epic Primary Care.

Please send **MOST RECENT 8 YEARS OF MAMMOGRAM IMAGES AND REPORTS** (VPN or cloud image transmission preferred, CD/ DVD or film also can be accepted)

If you do not have films/CDs or any exams on this patient, please call our office.

When my information is used of disclosed pursuant to this authorization, it may by Protected Health Information and subject to federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health Care Provider.

PATIENT SIGNATURE _____

DATE _____

Records should to be mailed and/or faxed to:

EPIC Health Headquarters
18000 W. 9 Mile Rd., Suite 200
Southfield, MI 48075
Phone: (248) 621-9443
Fax: (248) 416-1355