Diagnostic Radiology
Ultrasound & Breast Center, P.C.
Carolyn G. Dudley, MD

Medical Information Release Form (HIPPA)

Patient name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records, treatment rendered to me and claims and billing information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell (check all that apply)

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

All mammogram results will be mailed to you as required by the FDA.

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____