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AngelWilliamson
a place for hope, health and happiness
IMAGING CENTER

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RELEASE OF INFORMATION

PURPOSE: To establish those individuals with whom you allow Angel Williamson Imaging Center to share your personal protected health information. You may revoke release of information to any of the persons listed at any time.

Patient Name: ____ Date of Birth: __________________

I authorize Angel Williamson Imaging Center to share my Protected Health Information (PHI) with the following doctor(s) and/or individuals.

	Name	Relationship to Patient	Phone Number
1.	____________________	_______________________	___________________
2.	____________________	_______________________	___________________
3.	____________________	_______________________	___________________
4.	____________________	_______________________	___________________
5.	____________________	_______________________	___________________

Comments:
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__________________________________ __________________________________
Patient's Signature Date

MAMMOGRAM & BREAST ULTRASOUND PATIENTS:

Angel Williamson Imaging Center makes it a practice to call patients with medical test results. The phone number provided below will be the best phone number to contact me and/or leave a message concerning results:

Phone#:__________________________

__________________________________ __________________________________
Patient's Signature Date

cw 08.10.12
Revised: 06.15.15/cw
Review: 06.15.15