

FOR NUANCE POWERSHARE IMAGE TRANSFER SEND TO

UNIFIED WOMEN'S HEALTHCARE (HUB)



If mailing DVD send to below address

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____

Previous Name: _____

MRN# _____

I request and authorize _____

to release healthcare information of the patient named above to

**OB-GYN WOMEN'S CENTRE OF LWR LLC,
8340 LAKEWOOD RANCH BLVD. SUITE 240
LAKEWOOD RANCH, FL 34202**



The request and authorization applies to:

All Breast Imaging and Reports (Mammography and Ultrasound) for Continuum of Care.

PLEASE FAX REPORTS TO: 941-907-3036

Date requested: _____

Appointment date: _____

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 a 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." Effective Date: 9/28/2021