MILLENNIUM PHYSICIAN GROUP *Your Connection to a Healthier Life*	MAMMOGRAPHY RECORDS REQUEST FOR CONTINUING CARE OF PATIENT	PAGE: 1 OF 1 202102

Patient Name:	Patient ID:	DOB:	□ Male □ Female
Prior Films may be under Former Name:	Patient's Phone Number:	Exam Date:	

MAMMOGRAPHY FILM TRACKING:

Facility Name: _____

Address: _____

City/State: _____ Zip: _____

Phone No.: _____

PLEASE SEND CD AND REPORTS TO THE FOLLOWING LOCATION:

□ 19621 Cochran Blvd
Port Charlotte, Fl 33948

□ 1528 Del Prado Blvd S
Cape Coral, Fl 33990

□ 13813 Metro Parkway
Ft Myers, Fl 33912

□ 88 12th St North
Naples, Fl 34102

Patient Statement:

I understand that this authorization to discuss/disclose private health information to the designated person shall remain in effect for one year from the date of this signed release unless and until I have revoked the authorization by sending written notification.

I understand that the information that my MPG healthcare provider receives pursuant to this authorization may then be disclosed by him/her to a specialist to whom I am referred and that this re-disclosure is not a HIPAA violation

I understand I have the right to inspect the medical records requested.

I understand that I have the right to refuse the sign this authorization.

Printed patient name or legal representative: _____ Date: _____

Signature of patient or legal representative: _____ Date: _____

(Signature)