St. Louis
Breast Center

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Ballwin, MO 63011

Phone : 636-779-8008 Fax: 636-779-8010

Authorization to Release Medical Imaging Records

Patient Name: ____

Previous Name (if Applicable)______________________________

Patient DOB: ____

Please Release Films to: _______________________________

Address _______________________________

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Phone________________________ Fax ________________________

I understand that after the custodian of records discloses my health information, it may not longer be protected by federal privacy laws, By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient Signature ____

Today's Date ____