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CT Scans * Full Body Ultrasound * Bone Density (DEXA) Scans * Breast Imaging

2021 ROI- BDY-CT-Xray

**Authorization for Release of Information
 PRIOR CT, Body Ultrasound or X-RAY IMAGING / REPORTS**

MRN: _____

Patient: Please fill out the *Italicized* portions, so we can obtain your prior images/reports.

Full Name (First, Middle, Last): _____

Any other prior names: _____ *DOB:* _____ *SSN#:* _____

Where have you had prior Body Ultrasound Exams or X-Rays or CT Scans performed?

RELEVANT BODY PART (current problem area): _____

<i>Report Type (CT, Ultrasound or X-Ray)</i>	<i>Facility Name</i>	<i>City</i>	<i>State</i>

Facility: Please send prior Reports & Images to: Kentucky Breast Care & Somerset Family Imaging

Patient Consent:

I hereby authorize Kentucky Breast Care and Somerset Family Imaging to use or disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorization by this document is not a health plan or health-care provider that my information may no longer be protect from further disclosure by state or federal law. I understand this release permanently transfers my records to Kentucky Breast Care and Somerset Family Imaging.

I understand that my healthcare will not be affected if I do not sign this form. I understand that I may revoke this authorization at any time by notifying Kentucky Breast Care and Somerset Family Imaging in writing, except to the extent that has already been taken in reliance to the previous authorization period. I understand that I have the right to receive a copy of this information, if I request it. I hereby authorize the use or disclosure of my individually identifiable health information described above. I understand that unless restricted by individual state laws, that this information may contain information about HIV, AIDS, Venereal disease or mental health disorders. I understand that the expectation to this authorization applies to (in accordance with CFR part 2) records containing drug or alcohol abuse or therapist psychiatric notes. These record types require a separate authorization and are not included in this consented release of information.

Signature of Patient or Patient Representative

Date

For Fastest Results: Before your appointment, please return this signed release to us, OR Drop off / Mail ALL Prior Imaging Disks & Reports to:



KBC / Somerset Family Imaging
 100 Sarah's Ln, Somerset, KY 42503
 Fax: 606-678-8368

Locations:

100 Sarah's Ln, Somerset, KY 42503
 38 Dr. Joe T. Pettey Dr., Russell Springs, KY 42642