BREAST CENTER
of ACADIANA

NOTE: It is the policy of Breast Center of Acadiana that this release **MUST** be signed annually.

Authorization to Release Confidential Healthcare Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Work Number: _____

Cell Number: _____ Email: _____

Social Security Number: _____

I hereby authorize the RELEASE of all my imaging records to include: film, CD, and final reports. My imaging records can be obtained from: (place where the last mammogram was performed). I also authorize the release of future reports related to breast imaging, surgery or pathology, to the Breast Center of Acadiana.

Facility: _____ Date/Yr of Mammogram: _____

Facility: _____ Date/Yr of Mammogram: _____

The imaging records should be sent to Breast Center of Acadiana, 1700 Chemin Metairie, Bldg. 2, Ste. 701, Youngsville, LA 70592.
Phone number: 337-504-5000 Fax: 337-504-5646

In the future, if I need my imaging records sent to another facility, I give Breast Center of Acadiana my permission to release my records to include: film, CD and final reports.

Signature: _____ Date: _____