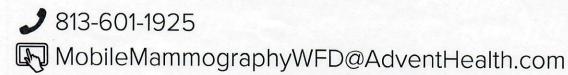


## **MOBILE MAMMOGRAPHY** Patient Registration Form

Appointment Date:	Appointment Time:		
Patient Name:			
Mailing Address:			
City:			
	Date of Birth:		
INSURANCE INFORMATION			
Insurance Company:			
Member ID:			
Group Number:			
Relationship to Policy Holder:			
Physician's Full Name:			
	Suite:		
City:			
Phone:	Fax:		





## Form of Written Acknowledgment of Receipt of Notice of Privacy Practices

By signing this Written Acknowledgment of Receipt of Notice of Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of the Notice of Privacy Practices.

Patient or Legal Representative Signature

Printed Patient or Legal Representative Name

Date

## AdventHealth Mobile Mammography

Authorization to Release Previous Breast Imaging Records

To AdventHealth West Florida Imaging

Patient Name:	Name: Date of Birth:		
Phone Number:			
I herby authorize to obtain from: (Facility	Name/ Address/ Phone #)		
Facility/ Organization:			
Address:			
Phone #:			
These images and/or reports will be used	to compare with my present examin	nation	
Mammogram Images and Reports	Breast Ultrasound & Reports	Breast MRI & Reports	
Please F	Power Share if possible- Send report	ts/ images	
	AdventHealth West Florida Imagin	g	
	8702 Hunters Lake Dr Suite 150,		
	Tampa, FL 33647		
	Fax 813-436-8437		
	Office 813-601-1925		
I understand I may revoke this author organization in writing.	ization at any time by notifying the a	above referenced person/ physician	
l understand the revocation does not authorization. Unless revoked, this autho	apply to information that has alread rization will expire (12) months from	y been released in responded to this the date of this authorization.	
l understand that the information in r diagnoses, and/ or treatment.	ny medical record may include infor	mation about my medical history,	
Patient Signature:		_ Date:	
Patient Name:			