AdventHealth

MOBILE MAMMOGRAPHY
Patient Registration Form

Appointment Date:_____ Appointment Time: _____

Patient Name: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Date of Birth:_____

INSURANCE INFORMATION

Insurance Company: _____

Member ID:_____

Group Number:_____

Relationship to Policy Holder: _____

Physician's Full Name:_____

Street: _____ Suite: _____

City: _____ State:_____ Zip:_____

Phone:_____ Fax:_____

813-601-1925

MobileMammographyWFD@AdventHealth.com

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: _____ Date of Birth: _____

Phone Number: _____

I herby authorize to obtain from: (Facility Name/ Address/ Phone #)

Facility/ Organization: _____

Address: _____

Phone #: _____ Fax #: _____

These images and/or reports will be used to compare with my present examination

___Mammogram Images and Reports ____Breast Ultrasound & Reports ____Breast MRI & Reports

Please Power Share if possible- Send reports/ images

AdventHealth West Florida Imaging
8702 Hunters Lake Dr Suite 150,
Tampa, FL 33647
Fax 813-436-8437
Office 813-601-1925

___I understand I may revoke this authorization at any time by notifying the above referenced person/ physician organization in writing.

___I understand the revocation does not apply to information that has already been released in responded to this authorization. Unless revoked, this authorization will expire (12) months from the date of this authorization.

___I understand that the information in my medical record may include information about my medical history, diagnoses, and/ or treatment.

Patient Signature: _____ Date: _____

Patient Name: _____