BREAST SCREENING CENTER OF WESTERN NEW YORK

2828 Main Street • Buffalo, New York 14214-1722 • Phone (716) 838-1300 • Fax (716) 837-7725

CHART #:

PATIENT NAME: **DOB:** **GENDER:**

ADDRESS:

HOME PHONE NO: **CELL PHONE NO:**

SOCIAL SECURITY NO:

REFERRING PHYSICIAN:

CONSULTING PHYSICIANS:

Please read statements below including HIPAA guidelines.

AUTHORIZATION AND AGREEMENT TO RELEASE MEDICAL INFORMATION FOR COORDINATION OF CARE AND INSURANCE BILLING.

I hereby authorize the release of any necessary information and or records to the Breast Screening Center of Western New York in order to process the health insurance claim for services rendered. All information provided is and will be kept confidential. The Breast Screening Center of Western New York is a separate entity from the physician's office.

PER YOUR INSURANCE - DEDUCTIBLES/COPAYS/COINSURANCE MAY APPLY

I understand that I am responsible for payment of charges for services rendered. In the event that my account has to be sent to a collection agency and or attorney, I shall be responsible for all collection and or attorney fees.

I hereby give my authorization to obtain any follow-up surgical and or pathological reports from my health care providers in order to correlate with the findings of my mammogram.

I have been notified and or received a Notice of Privacy Practice of the Breast Screening Center of Western New York.

Date: **Signature:**