



509-315-4154

I \_\_\_\_\_ give Insight Thermal Imaging permission to electronically transfer my medical images via email, to the email address I have provided. Additionally, I would also agree to send these images electronically to the medical provider listed. (Provider listed under “Person In Charge of Your Breast Health” on your breast health history form).

Signed \_\_\_\_\_ Date \_\_\_\_\_

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