MWHC **Imaging Center for Women**
In partnership with
Radiologic Associates of Fredericksburg

Authorization to Release Confidential Medical Information 1300 Hospital Drive • Fredericksburg, VA 22401

I, _____ DOB _____
(Last Name, First Name)

Address _____City _____

State _____ Zip Code _____ Phone (_____) _____ - _____ Email_____

Authorize the following Mary Washington Healthcare System entity:

Imaging Center for Women

To release the information specified below, in accordance with the laws of the Commonwealth of Virginia, and Mary Washington Healthcare System policies, to the party identified below.

Electronic Transfer via PowerShare to:_____
Name: _____
Pick-Up Date:_____
Organization:_____
Street Address:_____
City, State, Zip:_____
Online Record eDelivery e-mail address:_____
Cost: CD's = $10 per, Thumb Drives = $20 per (when requested for personal record)
Information to be released:

□ Radiology Reports

□ Consultation

□ Other (please specify) _____

Dates of Service _____ to _____ Medical Record Number_____

The Imaging Center for Women
1300 Hospital Drive, Suite 100
Fredericksburg, VA 22401
(540) 741-3250 FAX (540) 741-3253

Imaging Center for Women at North Stafford
125 Woodstream Blvd, Suite 101
Stafford, VA 22556
(540) 657-9729 Fax (540) 657-9730

Authorization to Release Information: I hereby authorize, allow, and cause the release of information indicated above. No threat or other coercive measures have induced me to sign this form, and I do release Mary Washington Healthcare from, and covenant not to sue MWHC for any claim I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may request to inspect or copy any information used/disclosed under this authorization as provided in CFR 164.524. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event, or condition described as:_____ (if none specified, this authorization will expire 6 months after the date specified below.)

Patient Signature: _____ Date: _____
Parent/Guardian/Patient Designee Signature_____ Date:_____
Authority of Individual Signing for Patient: _____ Date:_____

Revised 3/8/2024