Imaging Center for Women

MWHC

In partnership with
Radiologic Associates of Fredericksburg

1300 Hospital Drive, Suite 100 • Fredericksburg, VA 22401
Telephone: (540) 741-3250 • **Fax**: (540) 741-3253

Authorization to Release Confidential Medical Information

I, (please print) _____ DOB_____SSN_____

Previous name(s)_____ hereby authorize the Imaging Center for Women to obtain the information specified below, in accordance with the laws of the Commonwealth of Virginia, and Mary Washington Healthcare System policies, from the party identified below:

Organization _____

Street Address _____

City, State, Zip Code _____

Telephone Number: _____

Fax Number: _____

Please mail to:

Imaging Center for Women
Attn: File Room
1300 Hospital Drive, Ste 100
Fredericksburg, VA 22401

Information to be released:

- ☐ Mammograms (Dicom Compatible CD preferred)
- ☐ Breast Ultrasounds (Dicom Compatible CD preferred)
- ☐ Full DEXA Reports
- ☐ Radiology Reports

WE DO NOT ACCEPT ENCRYPTED CDs OR FILM

- ☐ Purpose for the disclosure of the above information is for **Continuing Care** at the Imaging Center for Women.
- ☐ Purpose for the disclosure of the above information is for **Permanent Transfer** of my records to the Imaging Center for Women.

I understand that I may revoke this authorization at any time by sending a written request to the entity/person I authorized to release the information. **This authorization will expire 1 year after the date specified below.**

Patient Signature _____ Date _____
Parent/Guardian/
Patient Designee Signature _____ Date _____

Authority of Individual Signing for Patient _____ Date _____