MWHC

Imaging Center for Women

In partnership with
Radiologic Associates of Fredericksburg

1300 Hospital Drive, Suite 100, Fredericksburg, VA 22401
Telephone: (540) 71-3250• **Fax:** (540) 741-3253

Authorization to Release Confidential Medical Information

I, (please print)_____DOB_____

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 Washinton Healthcare System policies, from the party identified below:

Organization_____

Street Address_____

City, State, Zip Code_____

Telephone Number:_____

Fax Number:_____

Electronic Transfer via PowerShare to:
Mary Washington Healthcare

-OR-

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 Ultraasounds (DICOM Compatible CD Preferred)
- ☐ Full DEXA Reports

- ☐ Purpose of the disclosure of the above information is for **Continuing Care** at the Imaging Center for Women.
- ☐ Purpose of 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_____