AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR IMAGING

PATIENT NAME:____ MR#__________________________

OTHER NAME RECORDS MAY BE UNDER (MAIDEN NAME) ___________________________________

PATIENT DATE OF BIRTH________________________________

DATE OF SERVICE______________________________________

IMAGES/RECORDS TO BE RELEASED_________Mammogram_________________________________

_____XX____CD (DICOM FORMAT) _____XX______REPORT

RECORDS TO BE RELEASED FROM THE FOLLOWING

NAME OF FACILITY/PHYSICIAN____

ADDRESS/LOCATION____

TELEPHONE NUMBER____

FAX NUMBER____

The purpose of the disclosure of the above records and/or images is for **COMPARISON.**

This authorization shall remain in effect for one (1) year from the date of this authorization.

Please release the records and/or images noted above to VALLEY VIEW MEDICAL CENTER.

_______________________________________ ______________________________

Signature of Patient or Legal Representative **Date**

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If signed by other than patient, indicate relationship

PLEASE SEND RECORDS REQUESTED PER ABOVE TO THE ADDRESS BELOW. ATTN: MAMMO DEPARTMENT

FAX: 928-788-4919 PHONE: 928-788-7228

5330 S HIGHWAY 95

FORT MOHAVE, AZ 86426