

ULTRASOUND ASSOCIATES

Women's Imaging Center

5055 SEMINARY ROAD, SUITE 104
ALEXANDRIA, VA 22311
TEL 703 820-8295 FAX 703 820-8366

REQUEST TO RELEASE HEALTH INFORMATION

PLEASE SUBMIT THIS COMPLETED FORM DIRECTLY TO THE FACILITY THAT PERFORMED YOUR PRIOR EXAMS.

PATIENT NAME: LAST FIRST MI DATE OF BIRTH:

DAY PHONE: ALTERNATE PHONE:

I hereby authorize: (NAME OF FACILITY TO RELEASE HEALTH INFORMATION)

to release the following records to Ultrasound Associates at the above address and/or the patient.

INFORMATION TO BE RELEASED:

CD'S ARE PREFERRED

Mammography Films/CD'S/Reports -- Specify Dates

\*\*Please send only the patient's two most current mammography studies from your facility.\*\*

Sonography CD'S/Reports -- Specify Dates

Bone Density Images/Reports -- Specify Dates

I understand and accept full responsibility for the transfer of the films/images.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

IF SIGNED BY LEGAL REPRESENTATIVE SPECIFY RELATIONSHIP TO PATIENT DATE

FOR OFFICE USE ONLY
PAT ACCT#:
DATE FAXED TO FACILITY: INITIALS:
DATE RECEIVED: INITIALS:

PLEASE RETURN A COPY OF THIS LETTER WITH THE REQUESTED INFORMATION AS SOON AS POSSIBLE TO ULTRASOUND ASSOCIATES AT THE ABOVE ADDRESS. PLEASE CONTACT ULTRASOUND ASSOCIATES IF YOU ARE UNABLE TO LOCATE THE REQUESTED RECORDS.