ULTRASOUND ASSOCIATES
Women's Imaging Center

5055 SEMINARY ROAD, SUITE 104
ALEXANDRIA, VA 22311
TEL 703 820-8320 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: _____ DATE OF BIRTH: _____
LAST FIRST MI

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.

INFORMATION TO BE RELEASED:

☐ Mammography Films/CD'S/Reports -- Specify Dates_____

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

☐ Sonography Films/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.