AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize

Facility Name: _____

Phone Number: _____

Fax Number: _____

to release healthcare information of the above named patient to:

The Paredes Institute for Women's Imaging

☐ 4480 Cox Road, Suite 100
Glen Allen, VA 23060

☐ 2530-C Gaskins Road
Richmond, VA 23238

This request and authorization applies to:

☐ BREAST IMAGING STUDIES _____

☐ MEDICAL INFORMATION _____

CD's or copies of images will not be returned.

Original films will be returned to the providing facility.

SIGNATURE: _____ DATE SIGNED: _____