

Authorization to Obtain Breast Imaging Records

Patient Information

Patient Name: _____ Date of Birth: _____

Other Previous Name(s) (if applicable): _____

Facility Releasing Records (location where you have had a mammogram)

Facility Name: _____ Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

Authorization & Signature

- I understand that this authorization permits the release of **breast-related records only, including mammography, breast ultrasound, breast pathology, and related reports**, as applicable, to Radiology Associates of Tallahassee, for diagnostic comparison and continuity of care purposes.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken and reliance on it.
- This authorization will expire one (1) year from the date of signature, unless revoked earlier in writing.

Signature of Patient or Authorized Representative: _____

Printed Name: _____

Relationship to Patient (if not patient): _____

Date: _____

Facility Releasing Patient's Records

The preferred methods of sending records are via:

PowerShare: Radiology Associates of Tallahassee, PA

Ambra: Share code is 1600 or email – wicfileroom@radassociates.com

Life Image: Women's Imaging Center of Tallahassee

If none of the options above are available, please mail a CD/DVD in DICOM format (no viewer on CD) to:

The Women's Imaging Center
Radiology Associates of Tallahassee
1600 Phillips Rd
Tallahassee, FL 32308