AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT NAME (please print): _____

DATE OF BIRTH: _____

PREVIOUS NAME: _____

SOCIAL SECURITY #: _____

I request and authorize _____
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-B & C Gaskins Road**
Richmond, VA 23238

This request and authorization applies to:

❑ MAMMOGRAPHY STUDIES _____

❑ MEDICAL INFORMATION _____

❑ I request that my mammograms be permanently transferred

❑ I request that my mammograms be returned to the sending facility

PATIENT SIGNATURE: _____

DATE: _____