REQUEST FOR PRIOR MAMMOGRAM AND/OR BREAST ULTRASOUND BREAST MRI FILMS/CD AND REPORTS

NORTHERN ARIZONA RADIOLOGY
77 WEST FOREST AVENUE, SUITE 101
FLAGSTAFF, AZ 86001
Phone: 928-773-2515 option 4
Fax number: 928-773-2521

This authorization for disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 et seq. and the Health Insurance Portability and Accountability Act 1996 (HIPAA).

It is very important that we obtain any prior mammogram, breast ultrasounds and/or breast MRI images and reports from other facilities where you had previous exams. Previous exams are used for comparison to provide the most accurate reading. Once we obtain your prior films, they are compared with your current study for reading by our board certified radiologist.

The maximum waiting period for prior studies is 4 weeks. If, at the end of this time the studies are not received we will process your current mammogram/Breast ultrasound/Breast MRI without comparison and we may ask you to return for additional imaging.

PLEASE PROVIDE THE FOLLOWING INFORMATION TO BE USED TO OBTAIN PRIOR IMAGING FROM AN OUTSIDE FACILITY:

(NAME OF THE OUTSIDE FACILITY)

(ADDRESS OF THE PRIOR FACILITY)

(PHONE NUMBER OR FAX NUMBER OF THE PRIOR FACILITY)

PLEASE PROVIDE YOUR INFORMATION TO REFERENCE THE PRIOR IMAGING

(PLEASE PRINT YOUR NAME AND DATE OF BIRTH)

(PLEASE INDICATE A PREVIOUS NAME IF APPLICABLE)

(HOW LONG AGO WAS ANY PREVIOUS IMAGING DONE)

By signing below I authorize the release of medical records to Northern Arizona Radiology, P.C. (NAR) and agree to hold harmless your facility for any action related to the release of records. Northern Arizona Radiology, P.C. agrees to return original x-ray films as soon as possible upon completion of care. I am aware that your facility may be unable to reproduce damaged or misplaced films. Records may not be released to another party without authorization, unless permitted by law.

(SIGNATURE) **(DATE)**

(IF SIGNED BY OTHER THAN THE PATIENT, INDICATE RELATIONSHIP)

PLEASE MAIL PRIOR IMAGINGAND REPORTS TO THE ADDRESS ABOVE. Revised 1/2016