MT BAKER IMAGING

BREAST IMAGING RELEASE FORM

MRN:

Patient Name: _____ Birth Date: _____

Alias/Maiden Names: _____ SSN (-xxxx): _____

I hereby authorize Mt. Baker Imaging to obtain medical records, including images and reports, from the below-named facility:

Prior Imaging Facility

Facility Name: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Images Requested for Comparison Purposes (continuation of care)

☐ Mammograms ☐ Breast Ultrasound ☐ Breast MRI ☐ Breast Biopsies

☐ Other _____

Mail DICOM formatted CD to:	**Or Send Electronically:**	**Fax Reports:**
Mt. Baker Imaging **Women's Diagnostic Center** **4029 Northwest Ave. #101** **Bellingham, WA 98226**	▫ eMix ▫ PACS (PeaceHealth Stentor_SCP)	(360) 752-0979

Please call (360) 788-9105 if:

- ▫ Patient had exam but no images are available
- ▫ There is no record of breast imaging for this patient
- ▫ Other _____

_____ _____

Signature of Patient Date

Office use only

Facility Phone: _____ Fax: _____ Attention: _____

The HIPPA Privacy Rule allows those doctors, hospitals and other healthcare providers that are covered entities to use or disclose protected health information, such as images, laboratory and pathology reports, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including provider who are not covered entities, to treat a different patient, or to refer the patient. Please refer to 45 CFR 164.506.