IMAGING FOR WOMEN
630 NW ENGLEWOOD RD.
KANSAS CITY, MO. 64118
PHONE: (816) 453-2700
FAX: (816) 453-9943

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

We'll take care of you.
Imaging for women

PATIENT NAME : _____

D.O.B.: _____ **MR#:** _____

INFORMATION TAKEN BY : _____
INITIALS *DATE*

I HEREBY AUTHORIZE IMAGING FOR WOMEN TO:

☐ RECEIVE FROM: NAME OF FACILITY OR DOCTOR _____

MAILING ADDRESS _____

☐ RELEASE TO: _____

PHONE _____ FAX

☐ **PERMANENT TRANSFER** (PER MQSA REGULATIONS 900.12{V}{4}) ☐ **We already have the patients films.**

☐ PICK - UP—DATE _____

☐ MAIL - DATE _____

TYPE OF FILMS AND REPORTS (INCLUDING PATHOLOGY) REQUESTED/RELEASED:

☐ MAMMOGRAM DATE OF EXAM(S) _____

☐ ULTRASOUND DATE OF EXAM(S) _____

☐ BONE DENSITY DATE OF EXAM(S) _____

☐ OTHER DATE OF EXAM(S) _____

FOR THE PURPOSE OF: (CHECK ALL THAT APPLY)

☐ COMPARISON ☐ SECOND OPINION ☐ SURGICAL CONSULT* ☐ OTHER _____

(UNLESS MARKED PERMANENT, FILMS WILL BE RETURNED AS SOON AS POSSIBLE)

*** IF THERE IS A BIOPSY PERFORMED, PLEASE FAX PATHOLOGY REPORT TO OUR OFFICE.**

PATIENT SIGNATURE: _____ DATE _____

WITNESS SIGNATURE: _____ DATE _____

COMPILED BY: _____ NOTES ENTERED INTO COMPUTER BY: _____ DATE _____