Virginia Women's Center

Breast Imaging Studies Request

I hereby request that my Breast Imaging studies be released from:

Facility: _____

Fax: _____

Address: _____

_____

_____

and Sent to:
Virginia Women's Center - Medical Records
CDs Mail To:
7130 Glen Forest Drive, Suite 101, Richmond, VA 23226

Secure Electronic Transmission:
RadConnect - Virginia Women's Center
LifeImage - recsmh@vwcenter.com

I understand that this authorization will be valid for one year.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Virginia Women's Center has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to Virginia Women's Center at the address checked above.

Please note: Films are returned to the originating facility following review and comparison.

_____ Date: _____

Printed Patient Name *Patient Signature*

Was your study performed under a different last name? If so, please indicate the name here: _____

Patient's Date of Birth:_____ Last Four Digits of Social Security Number: _____

Reason for Transfer: New Location

Appointment Date with VWC ____/_____/_____ Date of Last Mammography _____/_____/_____