UNC BREAST IMAGING
UNC HOSPITALS
101 MANNING DRIVE
CHAPEL HILL, NC 27514
ATTN: MAMMOGRAPHY DEPT
(984)974-8132 **FAX (984)974-8582**

RELEASE OF MAMMOGRAPHY INFORMATION

UNC MRN: _____

TODAYS DATE : _____/_____/_____

PATIENT NAME : _____ (Maiden Name) _____

PATIENT DOB : _____/_____/_____ DATE OF PRIOR MAMMOGRAM _____

FACILITY NAME : _____

FACILITY ADDRESS: _____

_____

FACILITY PHONE #: (_____) _____

FACILITY FAX #: (_____) _____

PLEASE SEND THE PAST 5 YEARS OF MAMMOS W/3D TOMO SERIES (IF AVAIL.) BREAST US/MRI BREAST IMAGES & REPORTS ON THE ABOVE PATIENT.

By signing this form you give UNC Breast Imaging permission to request your prior mammograms/breast ultrasounds and imaging report(s). Your prior images are needed for the completion of your mammogram. We are not requesting any other medical information on you. Final results of your mammogram will be mailed to you once prior images are received and compared. I understand that: I may revoke this authorization in writing. The procedure for revoking this authorization is to present my written revocation to the Medical Information Management Department. I may refuse to sign this authorization. UNC Hospitals will not condition my treatment, any payment, enrollment in health plan, or eligibility for benefits on receiving my signature on this authorization. I have been informed and understand that information disclosed pursuant to this authorization may be subject to disclosure by a recipient of such information. It is possible that once disclosed the privacy of the information may no longer be protected under federal medical privacy law. Unless otherwise revoked, this authorization will expire in 90 days on the following date: _____.
I intend to maintain a permanent record of my images at UNC.

PATIENT SIGNATURE : _____

DATE: _____

REQUEST VIA PHONE _____ REQUEST VIA FAX _____

FIRST ATTEMPT _____
SECOND ATTEMPT _____
THIRD ATTEMPT _____
NOTES: _____
_____