

REQUEST FOR MEDICAL RECORDS RELEASE FORM — PRIOR STUDIES

In order for Inland Imaging radiologists to make appropriate conclusions concerning a patient’s medical imaging studies, previous studies may be necessary for that patient. We are requesting copies of the patient’s previous imaging studies and reports associated with those studies in order to perform treatment related services. Therefore, no authorization is needed from the patient.

The HIPAA Privacy Rule Section 45 CFR 164.506 – on Uses and Disclosure for Treatment, Payment, and Health Care Operations allows for release of previous studies to treating providers as stated:

A covered entity may, without the individual’s authorization:

- Disclose protected health information for the treatment activities of any health care provider (including providers not covered by the Privacy Rule). For example:
 - A primary care provider may send a copy of an individual’s medical record to a specialist who needs the information to treat the individual.

Please send 3 years of Prior Mammograms and Breast Ultrasound studies and reports (pathology if related). **If sending a CD it needs to be Non-Compressed Raw Dicom format.**

Patient Name: _____ Alias: _____
 DOB: _____
 Date: _____ Signature: _____

Attention: _____
 Physician/Facility Name: _____
 City, State, Zip: _____
 Phone: _____

Please confirm that you have received this release. Contact information is below if you have any questions. Thank you.

Holy Family Imaging Center
 5715 N. Lidgerwood
 Spokane, WA 99208
 Attn: Mammography
 Phone: (509) 363-7996
 Fax: (509) 363-7786

Providence Medical Park
 16528 E. Desmet Ct,
 Suite A1300
 Spokane, WA 99216
 Attn: Mammography
 Phone: (509) 363-7483
 Fax: (509) 363-7765

Sacred Heart Imaging Center
 105 West 8th Avenue, Suite 100C
 Spokane, WA 99204
 Attn: Mammography
 Phone: (509) 363-7863
 Fax: (509) 363-7868

CONFIDENTIALITY NOTICE

The information in this transmission is privileged and confidential. It is intended for the use of the recipient named, or the employee or agent responsible to deliver it to the intended recipient. If you received this in error, please notify us by telephone immediately and return the original message to us at the above address via US postal service. Any dissemination, distribution or copying of material received in error is strictly prohibited. We will be happy to reimburse you for any phone and postal costs involved in notifying us of our error. Thank you. Inland Imaging, LLC.

MEDICAL RELEASE WORKSHEET

First Name: _____ **Last Name:** _____ **MI:** _____

Facility Name #1: _____

Facility City/State: _____

Facility Phone: _____ Facility Fax: _____

Ordering Provider (for prior mamms): _____

Approximate Year: _____

Facility Name #2: _____

Facility City/State: _____

Facility Phone: _____ Facility Fax: _____

Ordering Provider (for prior mamms): _____

Approximate Year: _____

Kaiser ID#: _____