Inland Imaging®

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

02.07.2023

Inland Imaging®

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#: _____