WESTMED MEDICAL GROUP RADIOLOGY DEPARTMENT
2700 Westchester Avenue
Purchase, NY 10577
PHONE: 914-682-6416

REQUEST FOR RELEASE OF RADIOLOGY MATERIAL

Patient Name: ____

Patient Date of Service: ________________________________

Patient Date of Birth: ____

Date of Request: ____

Institution Name of previous Mammography: ____

Radiology telephone number: ____

Contact Information of person filling out this form: ____

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I hereby request that the Radiology Department release mammography images (film), and report be sent to: WESTMED Medical Group.

Name of facility: WESTMED Medical Group
Attn: HIM Dept.
Address: 2700 Westchester Avenue – 2nd. Floor
Purchase, NY 10577

Phone number : 914-682-6416

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TO BE READ AND SIGNED BY PATIENT:
I understand the following:

a. **I may revoke this authorization at any time by providing written notice to the practice.**
b. **I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtaining insurance coverage.**
c. **The practice will not condition treatment based on my signing this authorization.**
d. **I am signing this authorization freely and under no pressure from any individual to do so.**
e. **The information disclosed in this authorization may be subject to redisclosure by the practice and no longer be protected by federal law.**
f. **I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.**

________________________________ __________________
Patient signature/Designee ***Date***