Reston Radiology Consultants

Fair Oaks Imaging Center
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Breast Imaging Medical Record Release

Date: _____ DOB: _____ MRN#: _____

Patient Name: _____

To: ***PowerShare Accounts***
- ☐ FRC/RIA: 703.698.7944
- ☐ WIC-Reston/HCA: 703.639.9404
- ☐ Novant/UVA: 703.369.8675
- ☐ INOVA-Dulles: 703.391.3197
- ☐ INOVA-Loudoun/Peterson/Leesburg: 703.858.6622
- ☐ Valley Health/Winchester Medical Center: 540.536.2921
- ☐ StoneSprings Hospital: 571.349.4040

Fax Accounts:
- ☐ Kaiser: 703.934.5777
- ☐ WRA/Solis: 866.366.5798
- ☐ Fauquier Hospital: 540.316.4501

☐ Other: _____ Fax: _____

I am authorizing release of all Breast Imaging Studies (Mammography, Ultrasound, MRI, etc.) to include Images and Reports to the Loudoun Imaging Center Ashburn (LICA).

Please: _____ Mail CD and Reports to LICA

_____ Electronically send Images and Reports to LICA if possible

For any questions, please call _____

Thank you,

_____ _____

Printed Patient Name Patient Signature

For Internal Use ONLY:

1st Attempt: Date: _____ Time: _____ Initials: _____ Faxed: Yes No

2nd Attempt: Date: _____ Time: _____ Initials: _____ Faxed: Yes No

Revised: 7/20/2026