



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

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