Loudoun Imaging Center Ashburn
20905 Professional Plaza, Suite 100
Ashburn, VA 20147
P: 571.223.0230 F: 571.223.0330
LICA@restonradiology.com

Breast Imaging Medical Record Release

Date: ________________ DOB: ________________ MRN#: ______________________

Patient Name: ____

To: ☐ Fairfax Radiology ☐ RIA-Lansdowne ☐ RIA-Sterling

☐ WRA-Fairfax ☐ WRA-Sterling ☐ Kaiser

☐ INOVA-Dulles ☐ INOVA-Loudoun/Peterson/Leesburg

☐ NOVANT/UVA-Haymarket ☐ Winchester Medical Center

☐ StoneSprings Hospital ☐ WIC-Reston

☐ 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 RRC

For any questions, please call ________________________________

Thank you,

____ ____

Printed Patient Name Patient Signature

__Confidentiality Notice:__ This electronic message, together with its attachment, if any, is intended to be viewed only by the individual to whom it is addressed. It may contain information that is privileged, confidential, protected health information and/or exempt from disclosure under applicable law. Any dissemination, distribution or copying of this communication is strictly prohibited without our prior permission. If the reader of this message is not the intended recipient or if you have received this communication in error, please notify us immediately by return e-mail and delete the original message and any copies of it from your computer/fax system.

For Internal Use ONLY:

1st Attempt: Date: ______________ Time: _____________ Initials: ____________ Faxed: Yes No

2nd Attempt: Date: ______________ Time: _____________ Initials: ____________ Faxed: Yes No