Fair Oaks Imaging Center
4001 Fair Ridge Drive, Suite 103
Fairfax, VA 22033
P: 703.385.5203 F: 703.385.3058
FOIC@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 Fair Oaks Imaging Center (FOIC).

Please: _______ Mail CD and Reports to FOIC _____ Electronically send Images and Reports to RRC

For any questions, please call ___________________________________

Thank you,

____ ____

Printed Patient Name Patient Signature

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