New Hanover Regional Medical Center

NHRMC - Health & Diagnostics MCO
1135 Military Cutoff Rd, Suite 101
Wilmington, NC 28405
Phone: 910-662-8650
Fax: 910-256-0696

REQUEST FOR MAMMOGRAPHY RECORDS

COMPLETE EACH SECTION OF THIS AUTHORIZATION

Section A:

PATIENT IDENTIFICATION: _____
First Middle Maiden/Former Last

Social Security# XXX-XX-_____

Date of Birth_____ Medical Record # _____ optional

Phone # _____

SPECIFIC INFORMATION NEEDED:
All Breast Images and Reports (2 years if possible) including:
Mammography, Breast Ultrasound, Breast MRI and Breast pathology reports
CD-Di Com Form or PowerShare (New Hanover Regional Medical Center)

PURPOSE: Disclosure of this information is needed for continuity of care.

AUTHORIZATION: I authorize and request: _____
(Name of facility)

_____ _____ _____ _____
(Address) (City) (State) (Zip Code)

_____ _____
(Phone#) (Fax#)

to release the requested records to NHRMC.

Section B:
Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ☐ Yes ☐ No

Section C:
I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials** _____
I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I will be given a copy of this authorization form, after signing. **Initials** _____

Section D:
I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying the facility where the request was made in writing and that this authorization will automatically **expire on** _____/_____/_____ **(MM/DD/YY)** or 1 year from the date signed below, whichever is earlier. This hereby releases the sender from all legal responsibility or liability of the release of information described above from the records.

Printed Name: _____
(Patient or Authorized Representative)

Date: _____ **Signature:** _____
(Patient or Authorized Representative)

Witness: _____ _____
(Relationship if other than Patient)

Form of identification ☐ Drivers License ☐ State issued ID ☐ Military ID ☐ Other _____

PLEASE SEND THIS INFORMATION TO THE ATTENTION OF:	**SENDERS INFORMATION (NHRMC STAFF ONLY)**
NHRMC - Health & Diagnostics MCO 1135 Military Cutoff Rd, Suite 101 Wilmington, NC 28405 Phone: 910-662-8650 Fax: 910-256-0696	Fax to: _____ Number: _____ Address: _____ By Whom: _____ Date Sent: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

THIS FORM IS NOT PART OF THE PERMANENT MEDICAL RECORD