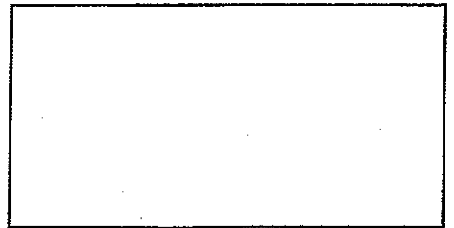
25 Well Street
Westerly, RI
02891-2934
(401) 323-3292



CONSENT FOR RELEASE OF MAMMOGRAM RECORDS

PATIENT NAME (PRINT): ______________________________ DOB: ______________

INFORMATION TO BE SENT TO:

WESTERLY HOSPITAL
25 WELLS STREET
ATTENTION: RADIOLOGY
WESTERLY, RI 02891-2934
(401) 348-3293

I HEREBY AUTHORIZE ____
(Name of Agency Sending Information)

____
(Address of Agency Sending Information)

TO RELEASE **MY PREVIOUS MAMMOGRAMS** TO THE WESTERLY HOSPITAL.

MY MOST RECENT MAMMOGRAMS WERE DONE ON: __________________________
(Date/s)

This Information is CONFIDENTIAL and is protected by state law and federal law which prohibit any further disclosure of this information unless further disclosure is permitted by written consent of the person to whom it pertains.

I understand this consent can be revoked by me at any time upon written request (not retroactively), and this authorization will expire 90 days from the date shown below unless revoked earlier.

____ ________________
Patient's Signature / Legal Representative / Parent / Guardian Date

TWH0001