Wake Internal Medicine Consultants, Inc.
THE TRIANGLE'S PREMIER MULTI-SPECIALTY CLINIC

Today's Date: _____ Patient DOB: _____

Patient Name: _____

I request and authorize my mammography medical records to be released for comparison from:

Name/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me to **Wake Internal Medicine Consultants, Inc. Blue Ridge.**

Please send **MOST RECENT 8 YEARS OF MAMMOGRAM IMAGES AND REPORTS** (VPN or cloud image transmission preferred, CD/ DVD or film also can be accepted)

If you do not have films/CDs or any exams on this patient, please call our office.

When my information is used of disclosed pursuant to this authorization, it may by Protected Health Information and subject to federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health Care Provider.

Signed by: _____ Date: _____

Records should to be mailed and/or faxed to:

Wake Internal Medicine Consultants, Inc. Blue Ridge
3100 Blue Ridge Rd Suite 200
Raleigh, NC 27612
Phone: 919-781-7500
Fax: 919-803-1742