



915 Highland Blvd.  
Bozeman, MT 59715  
Phone: (406) 414-5041  
Scheduling: (406) 414-5201  
Fax: (406) 414-1657

## **AUTHORIZATION FOR RELEASE OF MAMMOGRAPHY IMAGES OR FILES FOR CONTINUANCE OF BREAST CARE**

I, the undersigned authorize the release of my mammography images or files to Advanced Medical Imaging. I release Advanced Medical Imaging from all legal liability that may arise from release of information. These are to be retained at Advanced Medical Imaging permanently. \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Previous Name (if different): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Phone# \_\_\_\_\_

### **Facility Where Prior Mammograms/Breast related Imaging or Procedures Were Performed:**

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Phone #: \_\_\_\_\_ Facility Fax #: \_\_\_\_\_

We are requesting all the following:

- Mammograms (Films/Images and Reports)**
- Breast Ultrasound (Films/Images and Reports)**
- Breast biopsies (Films/Images and Reports)**
- Pathology Reports for Breast procedures**
- Breast MRI (Images and Reports)**

-----We can accept **\*\*PACS/EMix/SeeMyRadiology\*\*** – Call for information-----

**Please send to the following address:**

**Advanced Medical Imaging  
Attn: Film Library  
915 Highland Blvd.  
Bozeman, MT 59715  
(406) 414-5041  
Fax: (406) 414-1657**

**CONTACT PERSON:** \_\_\_\_\_