



**NEWTON-WELLESLEY  
HOSPITAL**

Department of Radiology  
**Women's Imaging Center**  
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**RADIOLOGY FILM/REPORT  
AUTHORIZATION TO RELEASE INFORMATION**

Date Requested: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ SS #: \_\_\_\_\_

I hereby authorize Newton-Wellesley Hospital to request the following information from, in accordance with established policy:

NAME OF FACILITY/MD: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

Mammograms on CD are okay as long as no other modalities are included in CD.

TYPE OF EXAM: MAMMO

DATE EXAM DONE: \_\_\_\_\_

FILMS

REPORT

REPORT&FILMS

Please forward these records as soon as possible to avoid delay in interpretation of my current exam. The films will be returned as soon as comparison interpretation is completed.

I understand that these records are a permanent part of my medical record and may be needed at a later date.

PATIENT SIGNATURE: \_\_\_\_\_.

IDENTIFICATION: \_\_\_\_\_.

PREPARED BY: \_\_\_\_\_ RELEASE BY: \_\_\_\_\_