AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (FLEMINGTON)

Patient's Last Name: ___________________________ Date of Birth: ___________________________

Patient's First Name: ___________________________ Former Name (if applicable): ___________________________

PID Number: ___________________________ Patient Phone: ___________________________

I request and authorize the following medical facility:

- ☐ Hunterdon Medical Center / Women's Imaging Center / 121 Route 31 / Flemington, NJ 08822
  P: 908.782.4700 / F: 908.782.0076
  Including HMC Women's Mammography Center and Kings Court
- ☐ Brems Imaging / 1 Dogwood Drive / Annandale, NJ 08801 / P:908.735.4477 / F:908.735.6532
- ☐ Hillsborough Radiology/375 Route 206/Hillsborough, NJ 08844 / P:908.874.7600 / F:908.874.7052
- ☐ Urgent Care Imaging /107 Cedar Grove Lane/Somerset, NJ 08873 / P:732.560.7172 / F:732.412.7225
- ☐ St. Luke's Hospital (all locations) / P:484.526.4719 / F:833.932.1185
- ☐ ____

To release the following healthcare information for the purpose of comparison to my newer studies to:

☑ Pink Breast Center
312 Walter E. Foran Blvd
Flemington, NJ 08822

Phone: 908.284.2300
Fax: 908.442.7432

This request and authorization apply to:

- ☑ Mammogram Films and Reports
- ☑ Ultrasound Films and Reports
- ☑ Biopsy Reports (if applicable)
- ☑ Bone Density / Dexa Reports (if applicable)

Patient* Signature: ___________________________ Date Signed: ___________________________

Printed Name: ___________________________

*or Legal Guardian and/or Authorized Representative