AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (FLEMINGTON)

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

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

PID (input by Pink) ________________________ Patient Phone: ________________________

I request and authorize the following medical facility (check one only):

- ☐ Hunterdon Medical Center / Women's Imaging Center / 121 Route 31 / Flemington NJ 08822
  P: 908.782.4700 / F: 908.782.0076
  Kings Court (now Hunterdon Medical Center)
  Women's Mammography Center (now Hunterdon Medical Center)
- ☐ 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
- ☐ Roseland Medical Imaging / 107 Cedar Grove Ln / Somerset NJ 08873 / P: 732.560.7172
- ☐ St.Luke's Warren Hospital / 185 Roseberry St / Phillipsburg NJ 08865 / P: 908.387.6111/F: 908.859.6817
- ☐ ____

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

- ☑ Pink Breast Center P: 908.284.2300
  312 Walter E. Foran Blvd F: 908.442.7432
  Flemington, NJ 08822

This request and authorization apply to:

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

Patient* Signature: ________________________ Date Signed: ________________________

Printed Name: ________________________
*or Legal Guardian and/or Authorized Representative