AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (PATERSON)
AUTORIZACION PARA LIBERAR INFORMACION SOBRE LA SALUD (PATERSON)

Appelido del Patiente:
Patient's Last Name: _____

Fecha de nascimiento:
Date of Birth: _____

Nombre del Patiente:
Patient's First Name: _____

Former Name
(if applicable): _____

PID (input by Pink) _____

Numero de telefono:
Patient Phone: _____

Solicito y autorizo lo siguiente centro medico (Marque solo uno).
I request and authorize the following medical facility (check one only):

- ☐ **St. Joseph's Regional Medical Center** / 703 Main St, Paterson ___ **T:** 973.754.2655 **F:** 973.754.2694
- ☐ **St. Joseph's Imaging Center** / 1135 Broad St # 3, Clifton _____ **T:** 973.569.6300 **F:** 973.754.2694
- ☐ **Allwood Imaging** / 914 Clifton Avenue, Clifton _____ **T:** 973.777.5022 **F:** 973.594.4769
- ☐ **Diagnostic Imaging of Clifton** / 1115 Clifton Ave #1, Clifton _____ **T:** 973.777-4222 **F:** 973.777.0702
- ☐ **Diagnostic Radiology Assoc.** / 1339 Broad St, Clifton _____ **T:** 973.778.9600 **F:** 973.778.4846
- ☐ **St. Joseph's Wayne Hospital** / 224 Hamburg Turnpike, Wayne ___ **T:** 973.956.3312 **F:** 973.389.4020
- ☐ **University Imaging** / 246 Hamburg Turnpike, Wayne _____ **T:** 973.942.2266 **F:** 973.970.7397
- ☐ **Medical Park Imaging** / 330 Ratzer Road #A6A, Wayne _____ **T:** 973.696.5770 **F:** 973.633.1204
- ☐ **Fair Lawn Diagnostic** / 19-04 Fair Lawn Ave, Fair Lawn _____ **T:** 201.794.3132 **F:** 201.794.6291
- ☐ **St. Mary's Hospital** / 350 Boulevard, Passaic _____ **T:** 973.365.4450 **F:** 973.916.2033
- ☐ **Hackensack Univ. Medical Center** / 30 Prospect, Hackensack ___ **T:** 201.966.2960 **F:** 201.525.0843
- ☐ **Teaneck Radiology** / 699 Teaneck Road #105, Teaneck _____ **T:** 201.836.2500 **F:** 201.836.7921

☐ **Otro:**
Other: _____

Para liberar la siguiente informacion de salud con el proposito de comparacion con mis estudios mas recientes para:
To release the following healthcare information for the purpose of comparison to my newer studies to:

☑ Pink Breast Center
680 Broadway / Suite 111 / Paterson, NJ 07514
Phone: 973.977.6662 Fax: 973.341.1128

This request and authorization apply to:
Solicitud y autorizacion se aplican a:

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

Firma del Patiente:
Patient* Signature: _____

Fecha de firma:
Date Signed: _____

Nombre del Patiente:
Printed Name: _____

*or Legal Guardian and/or Authorized Representative