



**Suburban Imaging - Burnsville**  
 14000 Nicollet Ave. S., Suite 204 | Burnsville, MN 55337

**BREAST IMAGING & MAMMOGRAPHY RELEASE FORM**

Please fax this release to **952.829.0297** or mail to:  
**Suburban Imaging Film Room 6441 Cecilia Circle, Bloomington, MN 55439**

Dear Patient:

According to the Mammography Quality Standards Act (MQSA), **it is essential that we have access to your previous mammogram films or any breast imaging exams, reports and records from any breast surgery** you have had, as well as records of breast care you receive following this mammogram. Many sites require that you sign a release before they will send these records to us. Please sign this release form.

I AUTHORIZE AND REQUEST THAT A COPY OF ANY PORTION OF MY MEDICAL RECORD WHICH MAY BE REASONABLY RELATED TO BREAST CARE, INCLUDING ANY MAMMOGRAM FILMS AND REPORTS, BE RELEASED AND SENT TO THE ADDRESS BELOW.

Location of previous breast imaging exams: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Year(s) of breast imaging exams: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Phone Numbers: \_\_\_\_\_ Cell #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Credentials of Legal Representative: \_\_\_\_\_ Verified By (Employee Initials): \_\_\_\_\_

**COPY CREDENTIALS AND SCAN WITH RELEASE.**

Mark X in appropriate box below:

I am requesting these films be **permanently transferred** to the facility listed below.  
 (Copy legal document and scan into patient record.)

I am requesting these films be **loaned** for comparison and returned to the originating facility.

Please send images and reports to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (Address and Phone Number)

- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire one year from the date of my signature or less as specified here \_\_\_\_\_ (expiration date).
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- I understand that once information is released pursuant to this authorization, Suburban Imaging cannot prevent re-disclosure of information to another third party from which the information was released to.