Leila J. Eisenstein Breast Center
At Providence Medford Medical Center
1698 E. McAndrews Rd, Ste 180
Medford OR 97504
t:541-732-6100
www.providence.org/medford

RELEASE OF INFORMATION

PATIENT NAME: _____

MAIDEN NAME OR PREVIOUS NAMES: _____

DATE OF BIRTH: _____

REGARDING **DISCS - ONLY DICOM FORMAT (NON-COMPRESSED)

THIS IS TO AUTHORIZE THE RELEASE OF **BREAST IMAGES AND REPORTS** REGARDING THE ABOVE PATIENT FROM:

NAME OF FACILITY: _____

ADDRESS: _____

CITY: _____ STATE: _____

PHONE: _____ FAX: _____

PLEASE SEND REQUESTED INFORMATION TO:

LEILA J. EISENSTEIN BREAST CENTER
1698 E MCANDREWS SUITE 180
MEDFORD, OR 97504

PHONE: (541) 732-6103
FAX: (541) 732-6120

THANK YOU

I, hereby, consent to the release of the above information. The original signed authorizations shall be kept at Providence Medical Imaging Department and is valid for six months unless revoked in writing earlier. Records obtained as authorized by this consent for information release will be maintained in accordance with federal confidentiality regulations (Title 42 of the Federal Register), which prohibits re-disclosure.

SIGNATURE: _____ DATE: _____