Mount Sinai *Dubin Breast Center* of the Tisch Cancer Institute

Radiology Breast Imaging Request

Dubin Breast Center, Radiology Department
Tel.: [redacted] Option 1, Option 3
FAX: [redacted]

Film Library
Tel.: [redacted]
FAX: [redacted]

Patients Name: *First*: _____ *Last*: _____ *Middle* _____

MRN: _____ **DOB:** _____ **Telephone Number:** _____

Address: _____

_____

Records Requested	Dates of Service	Exam Type
☐ Imaging **Reports Only**	☐ All on file ☐ Specific Date Range: ☐ Specific Date:	
☐ Imaging on a **CD –** ***Digital copy of images on a disc***	☐ All on file ☐ Specific Date Range: ☐ Specific Date:	
☐ Imaging printed on **Film -** ***Photographic hard copy film***	☐ All on file ☐ Specific Date Range: ☐ Specific Date:	

If you are requesting images for a physician to review then please check with the physician's office on the kind of imaging format they prefer, ***CD or Film.***

We will not condition treatment or payment on whether you sign this authorization. However, if you refuse to sign we will not release your records.

Patient Understanding Signature

By signing below, I am requesting that Mount Sinai provide me with access to health information in the manner described above. I understand that I will be contacted if any fees as a summary or explanation may be charged for fulfilling this request, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

Patient Signature_____ **Date:** _____

Personal Representative: _____ Print Name: _____

Authority: _____Date: _____

Send To - *Include Name of Receiver, Full Address including Zip Code, and FAX number if applicable:*

_____

_____

_____

_____

_____

Imaging with report to be:

☐ Mail Out to Above Address

☐ Pick Up

- ☐ At Dubin Breast Center Welcome Desk – **1176 5th Ave, First Floor, Cross Street 98th Street, New York, NY, 10029**
- ☐ At Radiology Associates Film Library – Mount Sinai Hospital, Radiology Associates Film Library, **1468 Madison Ave., Cross Street 100th Street, MC Level, Main Corridor, New York, NY 10029**

☐ FAX Reports to the Above Fax Number

For (Hospital) Use Only

Date Received: (MO/DY/YR) _____/_____/_____

Disposition of Request: _____ GRANTED _____ DENIED _____ PARTIALLY DENIED

Patient Notified in Writing Of Response On This Date: (MO/DY/YR) _____/_____/_____

Fee Charged For Fulfilling This Request (if applicable): $ _____

Name or Initials of Records Department Staff Member Processing This Request: _____