



Request for Outside Health Information

To: _____

Telephone: _____

Fax #: _____

I _____ hereby authorize you to disclose my health information to:

Summit Health
Imaging Department
1 Diamond Hill Road
Berkeley Heights, NJ 07922
Attention: Mammography Coordinator

Telephone: 973-404-9888

Fax: 908-277-8774

Specify Information Required:

All breast related studies and procedures including mammography, ultrasound and breast MRI.

Please include all reports.

Please send studies on a DICOM CD.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

******If you are unable to process this request, please contact our office at 973-404-9888******