BREAST CARE FOR Washington DC
QUALITY. CARE. COMMUNITY.

Mammogram Records Release Form

Date:_____

Patient Name: _____

Date of Birth: ____/____/____

I authorize the release of original Mammogram images in **either Dicom format on CD or analogue format <u>and</u> their imaging/diagnostic REPORTS** as specified below:

FROM:

Facility Name:_____

MAIL TO:
Breast Care for Washington
4 Atlantic St. SW
Washington, DC 20032
Fax: 202-905-0159

Reason for Release:

Comparison with other exam and/or follow-up or further treatment

PLEASE FAX BACK IF:
___Patient had exam there and films are not available
___There is no record of a mammogram done for this patient
___Other:_____

_____
Signature of Patient or Authorized Representative Date

_____
Relationship to Patient