AUTHORIZATION OF RELEASE OF MEDICAL RECORDS AND FILM FOR MAMMOGRAPHY

Facility:
Address:
City, State, Zip:

In Compliance with FDA/MQSA Citation 900.12 (c):
Facility shall upon request or on behalf of, by the patient, permanently or temporarily transfer the **ORIGINAL** mammograms and copies of patient's report to a medical institution, physician, or to the patient directly.

PATIENTNAME: _____
DATE OF BIRTH: _____ MEDICAL RECORD #: _____

I hereby authorize the release of ORIGINAL MAMMOGRAM FILMS, BREAST ULTRA SOUND, BREAST MRI, and related reports to:

_____
_____
_____
_____
_____

I request that these records (ORIGINAL FILMS and REPORTS) be released for
30 days ☐ Permanent Transfer ☐

I understand that any fees associated with this transfer are my responsibility.

Patient Signature _____ Date: _____
Signature of Authorized Party (If Applicable) _____ Date: _____

☐ ***Patients IDENTITY was verified (by viewing picture ID)***
Mandatory!

FACSIMILE NOTICE:
This notice is intended only for the use of the individual or entity named above and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication by error, please notify us immediately.