PHONE: 561-361-7872 FAX: 561-361-7873

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Our radiologist may want to compare the imaging taken here at Care Diagnostics to the imaging and reports from other facilities you have been to in previous years.
Comparison is an essential part in the reading and interpretation of breast imaging.

I, ______________________________ (PATIENT NAME) DOB: ____________

GIVE AUTHORIZATION TO ______________________________________ PRIOR (FACILITY NAME)

PHONE # ____________________ FAX #__________________ TO RELEASE

ALL OF MY BREAST IMAGING, REPORTS, & PATHOLOGY RECORDS TO

CARE DIAGNOSTICS
8903 GLADES ROAD
SUITE H1
BOCA RATON, FL 33434

PLEASE MAIL **ALL** PRIOR BREAST IMAGING ON A CD AND THE PRINTED REPORTS.

DO NOT SEND CDS THAT ARE ENCRYPTED OR REQUIRING A PASSWORD!

PATIENT SIGNATURE: ____________________________ DATE: _________

WITNESS SIGNATURE: ____

THIS MEDICAL RECORDS RELEASE EXPIRES 365 DAYS AFTER SIGN DATE.