DIAGNOSTIC CENTER FOR women

7500 S.W. 87 Ave.
Suite 100
Miami, FL 33173
(p) 305-740-5100
(f) 305-596-4960

MAMMOGRAPHY FILM RELEASE

FAX THIS FORM TO: 305-596-4960

PATIENT NAME:_____ DATE:_____

DATE OF BIRTH:_____ S.S. NUMBER:_____

MR#: _____ Phone #: _____

Referring MD: _____

The radiologist may want to compare your mammogram with any previous mammograms you have had performed elsewhere. Comparison is an essential part of mammography interpretation. Please follow up after today's visit to assure that your films have been received.

Name of institution where you had your previous mammogram:

_____

Dates of previous mammograms:

_____

PLEASE SEND FILMS OR CD ALONG WITH THIS FILM RELEASE TO:

DIAGNOSTIC CENTER FOR WOMEN, LLC
ATTN: FILM LIBRARIAN
7500 S.W. 87 AVENUE
SUITE 100
MIAMI, FL 33173

AS OF APRIL, 1999 THE FDA REQUIRES THAT **ORIGINAL** MAMMOGRAMS BE RELEASED TO THE PATIENT. PLEASE BE CERTAIN THIS FORM ACCOMPANIES THE FILMS/CD AND REPORTS. THANK YOU.

PATIENT SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____