DIAGNOSTIC CENTER FOR women

7500 S.W. 87th Ave., Suite 100
Miami , Fl. 33173
Office: 305-740-5100 ext: 2907
Fax: 305-596-4960

## Mammography Film Release

**Patient Name :**_____ **Date:**_____

**Date of Birth:**_____ **SS Number:**_____

**Patient Phone:** _____ **Referring MD:** _____

**MR#:** _____

**Film release expires one year from the date specified above.**

**The Radiologist may want to compare today's mammogram with any previous mammograms you have had performed elsewhere. Comparison is an essential part of mammography interpretation without the odds of missing a breast cancer increases. You are responsible for obtaining these films. Please follow up after today's visit to assure that your films have been received.**

**Name of institution where you had your previous mammogram:**

_____

**Month/ Year of your previous mammogram:**

_____

**ATTENTION: FILM LIBRARIAN/ FAX (305) 596-4960**
***DIAGNOSTIC CENTER FOR WOMEN, LLC***
**7500 SW 87th Avenue**
**Suite 100**
**Miami, FL 33173-5426**

**AS OF APRIL 1999 THE FDA REQUIRES THAT ORIGINAL MAMMOGRAMS BE RELEASED TO THE PATIENT**

**PLEASE BE CERTAIN THIS FORM ACCOMPANIES THE FILMS AND REPORTS. THANK YOU**

**PATIENT SIGNATURE:** _____ **DATE:**_____

**WITNESS:** _____ **DATE:**_____