



MAMMOGRAPHY FILM RELEASE

Please fax this form to 561-361-7873

Patient Name: _____ Date: _____

Date of Birth: _____

FILM RELEASE EXPIRES ONE YEAR FROM THE DATE SPECIFIED ABOVE.

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

PREVIOUS MAMMOGRAM INSTITUTION:

Fax Number: _____

Please send ALL PRIOR breast imaging.

Please send CD or films along with reports and this film release to:

Care Diagnostics
8903 Glades Road - Suite H-1
Boca Raton, FL 33434

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____