AUTHORIZATION FOR RELEASE OF MAMMOGRAM/ULTRASOUND IMAGES

Date: ________/________/__________

Facility of Previous Mammogram Films:

Facility Name: ____

Street Address: ____

City: ____________________________ State: ________ Zip: _______________

Phone: ___________________________ Fax: ____________________________

Last name at time of previous mammogram: ______________________________

*Please note, your exam will be held for 14 days prior to being read by the radiologists. ELH will make all attempts to acquire previous mammogram films for comparison.

I hereby authorize the practitioner of the facility listed above to release my **mammogram/breast ultrasound films/Pathology results** to

Eagles Landing Health
Imaging Center
1100 Hospital Drive
Stockbridge, GA 30281

Ph. 678-432-6161 Ext. 13144 **Fax** 678-432-3677

This authorization is valid from the date of my or my representative's signature below and shall expire in 366 days unless otherwise noted by me or my representative.

Patient Name: ___________________________________ Date of Birth: _______/_______/________

Signature of Patient: ______________________________________ Date: _______/_______/________

Name of Rep: _________________________Signature __________________________ Date: __________

Releasing Facility: please fax this form to Eagles Landing Health, Imaging Center.

Images PowerShared on:________________ Films/Images on CD/DVD Mailed on: ______________ No record in our system - Initial _________