REQUEST FOR RELEASE OF FILMS AND REPORTS

Patient Name:____

Date of Birth: ______________________   Telephone Number: ___________________

Previous or Maiden Name: ____

....

I hereby authorize Carolina Breast Imaging Specialists to release my films and reports to:

Name of Facility: ____

Address: ____

City, State, Zip: ____

This is a _____ Permanent or a _____ Temporary transfer (Check the area that applies).

Films are to be ____ mailed or _____ picked up by ____________________________. If authorizing another person to pick up films, that person's name is required. **Picture identification is required to obtain films and/or reports.**

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I hereby authorize:

Name of Facility: ____

Address: ____

City, State, Zip: ____

To release my films and reports to:

Carolina Breast Imaging Specialists
990 Johns Hopkins Drive
Greenville, NC 27834
Phone: 252.565.8951 Fax: 252.565.8958

Please notify us if you do not have the requested films.

This is a _____ Permanent or a _____ Temporary transfer (Check the area that applies).

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Patient Signature: ____ Date: ______________