RECORDS RELEASE FORM

TO: **Women's Center for Radiology**
1621 N. Mills Ave
Orlando, FL 32803
ATTN: MEDICAL RECORDS
407-841-0822 x. 141 / FAX 407-581-0861

This is to authorize the transfer of my medical records to the below named facility. **Please send all studies, reports, pathology, and images to:**

_____

_____

_____

FAX #:_____

My current reports may be delayed until prior films are available for comparison. The lack of comparison films may necessitate additional mammogram images, sonograms or other procedures.

Please forward my information to the receiving facility as soon as possible. Thank you.

PATIENT NAME: _____ DOB: _____

MAIDEN NAME: _____ SSN: _____

SIGNATURE: _____ DATE: _____

This form contains information of a personal and private nature. Please do not email this form.