REQUEST FOR RELEASE OF MAMMOGRAPHY FILMS AND REPORTS

This information is to be released:

To PROVIDENCE BREAST HEALTH CENTER
6600 Fish Pond Road, Suite 104
Waco, Texas 76710
Phone (254)235-3535
Fax (254)537-1798

FOR CONTINUUM OF CARE

From____

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Date________________________

Patient Name________________________________

Date of Birth____________________ SS#________________________

Signature of Patient________________________________

Note: This form is to be used when PBHC is requesting images from another facility for comparison