



Mammography Medical Release Form

I hereby authorize _____
(What facility was your last mammogram Performed?)

To release information from the medical records of:

Name of Patient: _____

Address: _____

City & State: _____ Zip: _____

Date of Birth: _____ SSN: _____

Reason for information release: to compare films from last mammogram

Information to be released: Mammography films or CD and report

Please fax/mail* images or CD and reports to:

Advanced Imaging
Attn: Mammography-Perla/Brandy
1750 N. Hampton Rd.
DeSoto, TX 75115
214-420-5400 Ext.411
Fax: 214-420-5412

Signature: _____ Date: _____

COURIER WILL PICK UP FILMS IF IT IS WITHIN A 15 MILE RADIUS