Carol Milgard
Breast Center

Image and Report Release

MRN _____

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____

Last Four Digits of Social Security # _____

Please mark appropriate selection:

I prefer my records to be sent in the form of:

- ☐ Reports
- ☐ Images on a CD
- ☐ BOTH

If known, please list exam(s) and date(s): _____

Please select a method of delivery:

- ☐ I would like a copy of my own records. Please mail to my address *(listed above.)*
- ☐ I will pick up my records at the breast center on _____ (date)
- ☐ Please release my records to _____ (name of person) on my behalf
- ☐ I would like a copy of my report faxed to this number: (_____) _____
  ☐ IDC

I hereby authorize Carol Milgard Breast Center to release my records.

Signature of patient (or legal representative) _____

If legal representive, explain relationship to patient _____

Date _____

☐ IDC
☐ SCN