DIAGNOSTIC IMAGING CENTERS, P.A.

MOBILE MAMMOGRAPHY

Medical Records Release

Patient Name: _____ Date of Birth: _____ MRN: _____

Prior Last Name (If Applicable): _____

Please provide the following information so that we may obtain your latest mammogram and/or other breast imaging records for comparison.

Name of Facility: _____

Address of Facility: _____

City/State/Zip: _____

I hereby authorize and request you to release all breast imaging medical records, including copies of reports in your possession to Diagnostic Imaging Centers, P.A.

_____ X_____ _____

Please print name | Patient or authorized signature | Date

REPORTS: Please fax reports to our Mobile Mammography Department at (913) 955-3744. If you need to speak to one of our Mobile Mammography Team Members, you can reach them at 913-222-9758 or 913-602-6692.

IMAGES: If you are unable to cloud images, please mail CD to our Medical Records department.

Diagnostic Imaging Centers, P.A.
6650 W. 110th St. Suite 100
Overland Park, KS 66211

Thank you !