RECORDS REQUEST FORM

Women's Center For Radiology

To Providing Facility: _____

_____

_____

FAX #: _____ PHONE #: _____

This is to authorize the transfer of my medical records to the below named facility. **Please send all:**

- ☐ Mammographic images
- ☐ Ultrasound images
- ☐ MRI images
- ☐ Reports
- ☐ Pathology Results
- ☐ Other:_____

Delivery via CD or DVD IS PREFERRED

Please forward my information as soon as possible to:

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

PATIENT NAME: _____ DOB: _____

MAIDEN NAME (if appropriate): _____ SSN: _____

CONTACT PHONE: _____ ALTERNATE PHONE: _____

SIGNATURE: _____ DATE: _____

WCR USE
Requested by: _____ *Date:* _____ *Jacket:* _____