Women's Center For Radiology

RECORDS REQUEST FORM

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 & Reports**
- ☐ **Breast Ultrasound Images & Reports**
- ☐ **Breast MRI Images & Reports**
- ☐ **Reports** _____
- ☐ **Pathology Results**
- ☐ **Other:** _____

Please share images via POWERSHARE to

Women's Center for Radiology
1621 N. Mills Ave.
Orlando, FL 32803
ATTN: Comparison Coordinator
407-581-0867 / FAX 407-581-0861

IF POWERSHARE IS NOT AVAILABLE, PLEASE MAIL CD/DVD WITH IMAGES IN **DICOM** FORMAT

Patient Name: _____ **DOB:** _____/_____/_____
(Nombre del Paciente) *(Fecha de Nacimiento)*

Maiden Name (if appropriate): _____
(Apellido de Soltera)

Contact Phone: _____
(Teléfono)

Signature: _____ **Date:** _____
(*Firma del Paciente)* *(Fecha)*

WCR USE
Requested by: _____ ***Req1:*** _____ ***Req2:*** _____ ***MRN:*** _____

IF EMAILING RELEASE BACK PLEASE SEND TO LCALDERON@WCRORLANDO.COM