

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 | ☐ Reports _____ |
| ☐ Breast Ultrasound Images & Reports | ☐ Pathology Results |
| ☐ Breast MRI Images & Reports | |
| ☐ 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