Southtowns Radiology
WOMEN'S CARE

I, _____request and authorize

_____ to release any information including diagnosis and records of treatment or examination rendered to me at your facility, to Southtowns Radiology.

____ ALL mammograms & most recent report, to include film screen mammograms and CDs for digital mammograms

____ Breast Ultrasound both report and CD

____ Breast MRI both report and CD

____ OTHER:

Patient's Full Name: _____

Patient DOB:_____ Phone: _____

Address: _____

Patient Signature: _____

Witness Signature: _____

Date Request Faxed:

Affix patient master label here:

In order to maintain accurate records for our AQ program, which follows all MQSA standards, we need to keep our patient files complete. The Mammography Department at Southtowns Radiology thanks you in advance for your kind and prompt attention to this request.

ACR ACCREDITED MAMMOGRAPHY FACILITY

HAMBURG OFFICE
3040 Amsdell Road
Hamburg, NY 14075
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FAX: 716.649.9005

ORCHARD PARK OFFICE
3050 Orchard Park Road
West Seneca, NY 14224
OFFICE: 716.558.5400
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