



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

The documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents or those documents is strictly prohibited. If you receive this in error, please notify the sender and arrange for the return or destruction of these documents.

3D Mammography | Breast Biopsy | Breast MRI | Bone Density | Ultrasound

www.SouthtownsRadiology.com/WomensCare

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