CHI St. Joseph Health

REQUESTS FOR RELEASE OF MAMMOGRAM(S) AND REPORTS

Patient Name: _____ MR#: _____

Previous or Maiden Name: _____ Date of Birth: _____

Telephone Number: _____ Social Security Number: _____

I hereby authorize St. Joseph Women's Imaging Center to release my mammogram(s) and reports to:

Name the Facility: _____

Address: _____

City, State, Zip: _____

This is a _____ permanent transfer or _____ temporary transfer. (Check the area that applies)

Mammogram(s) are to be _____ mailed or _____ picked up by me

I hereby authorize:

Name the Facility: _____

Address: _____

City, State, Zip: _____

To release my mammogram(s) and reports to:

CHI St. Joseph Health
Women's Imaging Center
2801 Franciscan Drive
Bryan, Texas 77802

Reason for request: The continuation of patient care at this facility.

Type of media preferred: ____ CD (**preferred**) ___ Film

This is a _____ permanent transfer or _____ temporary transfer. (Check area that applies)

Please notify us if you do not have the requested studies.

PHONE: 979-776-4927 FAX: 979-776-5321

Patient Signature: _____ Date: _____