DOCTORS IMAGING | ADVANCED RADIOLOGY. TRUSTED CARE.

Phone [504] 883-8111 • Fax [504] 883-3555

4204 Teuton Street • Metairie, LA 70006

Release of Breast Imaging Medical Records

Patient Name______________________________ **Date of Birth** ______________________________

Phone Number ______________________________ **Email** __________________________________

If you have had previous breast imaging done at another facility, please mark what types of exams were performed and list the facilities where they were performed. We will obtain those records so that our radiologists can compare your new and prior exams.

Please check all the exams that you have received previously:

☐ Mammography ☐ Breast Ultrasound ☐ Breast MRI

Please list the names of all facilities where you have previously received Breast Imaging:

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Medical records requested:

☑ **Reports**

☑ **Images on CD/DVD**

Release records to:

Doctors Imaging
Medical Records Department
4204 Teuton Street
Metairie, LA 70006
Phone 504-883-8111
Fax 504-883-3555

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

____
Signature of Patient/Legal Representative

____
Relationship to Patient and/or Date