BreastGyn Clinic

BREAST & GYNECOLOGICAL IMAGING

MEDICAL RELEASE FORMS

(PELVIC ULTRSOUNDS REQUEST)

PATIENTS FULL NAME ________________________________ **D.O.B.** ___/___/___

Patients Signature________________________________ **Date**_______________

Thank you for choosing to schedule your mammogram with PINK DOOR IMAGING. After the mammogram is performed, the radiologist will read your images. To provide you with the best quality of care, we may need to request your most recent mammogram from the prior facility.

(MAMMOGRAM & DIGNOSTIC REQUESTS)* *Please fill out completely*

DATE OF LAST MAMMOGRAM _______________

Location(s) ________________________________ **(*please specify campus*)**

Patients Signature________________________________ **Date**_______________

PLEASE SEND CD IMAGES & INCLUDE ALL REPORTS TO:

Pink Door Imaging
2424 W. Holcombe, Suite 102
Houston, Texas 77030
Fax: (832) 804-8120
Office: (832) 804-8119