PINK DOOR IMAGING

BreastGyn Clinic
BREAST & GYNECOLOGICAL IMAGING

Medical Record Release Form

PATIENTS NAME : _____

Date of Birth : _____

PREVIOUS FILMS/IMAGES AND CORRESPONDING REPORTS

DATE(S): _____

LOCATION: _____

PLEASE SEND ALL RECORDS TO:
Kathy Bivins MMG Dept
2424 W. Holcombe, Suite 102
Houston, Texas 77030

I am requesting a copy of my **previous mammogram(s) and/or breast ultrasound images, and/or all breast imaging studies** from the above entity for the purpose of comparison to current mammographic studies. As the person signing this consent, I understand that I am giving permission to the above named provider for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included in my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless recipient is a provider who makes disclosures permitted by law.

_____ _____

Patients Signature Date