EAGLES LANDING
FAMILY PRACTICE
Providing care at your convenience

AUTHORIZATION FOR RELEASE OF MAMMOGRAM FILMS

Date: ________/________/__________

Facility of Previous Mammogram Films:

Facility Name: ____

Street Address: ____

City: ___________________________ State: ________ Zip: _______________

Phone: __________________________ Fax: ____________________________

I hereby authorize the practitioner of the facility listed above to release my **mammogram/breast ultrasound films** to the Imaging Center of Eagles Landing Family Practice.

Please forward films or CD's and reports to:

Eagles Landing Family Practice
Imaging Center
1100 Hospital Drive
Stockbridge, GA 30281

678-432-6161 Fax 678-432-3677

Patient Name: ______________________________ Date of Birth: ______/______/_______

Signature of Patient: ________________________________ Date: ______/______/_______

Witness: ____ Date: ______/______/_______

Office Use Only:

Please advise whether or not previous images are available

_____ *Yes, we do have images and will send.*

_____ *No, we do not have patient/images on file.*