REQUEST TO OBTAIN MEDICAL RECORDS

I hereby authorize **Eunice Q. Sorin Women's Diagnostic Center** to obtain the following:

PREVIOUS STUDIES
MOST RECENT 2 YEARS NEEDED
DISCS PREFERRED (DICOM Format)/FILMS ACCEPTED

Please send any of the following that you may have:

- Mammogram films
- Breast ultrasounds
- Breast MRI studies
- Bone Density studies
- Lab results
- Medical reports
- Other information necessary for my medical treatment

From facility:

Facility Name: ______________________________

Street Address: ______________________________ Phone: ______________________________

City, State, Zip: ______________________________ Fax: ______________________________

Please indicate and fax back if:

____________ No record of this patient ____________ No mammo film / sono / reports

Please send to: **Atlantic General Hospital**
Attn: Women's Diagnostic Center
9733 Healthway Drive
Berlin, MD 21811
Phone: 410-641-9215
Fax: 410-641-9036

I authorize the release of my present and prior medical records pertaining to mammograms, breast ultrasound, breast MRI, breast biopsy and lab results and other information necessary for my medical treatment to **Eunice Q. Sorin Women's Diagnostic Center**.

Patient Name:______________________________ Patient Date of Birth:____________________

Patient Signature:______________________________ Date:______________________________

For Office Use Only:

Date of Mammo @ AGH:	Date Release Faxed:
Date Exam to be read by: (no later than 2 weeks)	Date Facility Called:
	Spoke With:
Date Courier to Pick Up Priors:	Request Number ☐ 1 ☐ 2 ☐ CD Failed to import
Confirmed study was mailed: ☐ Yes ☐ No If no, why?	