Information Request Release

Last Mammogram Facility: _____

City, State: _____

Patient Information

Name (please print): _____

Previous Last Name (please print): _____

Date of Birth: _____

Telephone Number: _____

Please release my mammography studies in a DICOM format via CD or films to:

Invision Diagnostics
127-D Wamsutta Mill Rd,
Morganton, NC 28655

Powershare: Invision Diagnostics
Fax: (704) 966-2407
Phone: (877) 318-1349

*please update your records, as our address has changed

Signature: _____

Date: _____

*** Please call or fax if no mammography studies are available ***

I, do hereby consent and authorize you to release copies of my medical records related to all breast procedures, including current and previous medical records from other practices and practitioners, hospitals, imaging centers, and/or clinics which are a part of my medical records. It may also include information concerning, Cancer, Cancer Testing, and Cancer Results. I agree that a copy of this release or a fax of this release shall be as valid as the original release.