VIRGINIA
WOMEN'S CENTER

Mammography CD Request

I hereby request that my most recent Mammography CD be released from:

Facility: _____

Fax: _____

Address: _____

_____

_____

and Sent to:

Virginia Women's Center – Medical Records
7130 Glen Forest Drive, Suite 101, Richmond, VA 23226
Phone (804) 288-4084
Fax (804) 282-2601

I understand that this authorization will be valid for one year.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Virginia Women's Center has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to Virginia Women's Center at the address above.

Please note: Original films are returned to the originating facility following review and comparison.

Patient's Signature_____ Printed Name_____

Date_____ Last four digits of Social Security Number_____ Date of Birth _____/_____/_____

Was your study performed under a different last name? If so, please indicate the name here_____

Reason for Transfer: New Location