



REQUEST FOR RELEASE OF MAMMOGRAMS

I authorize _____,
(Enter Up to 3 Names of Facilities if necessary. List City and State)

to release my mammogram images (preferably on disk) & printed (HARD COPY) reports for comparison purposes **AS SOON AS POSSIBLE** to:

**Department of Radiology
ATTN: MCXB-R, Radiology Film Library
Martin Army Community Hospital
6600 Van Aalst Boulevard
Fort Benning, GA 31905
Phone: 762-408-2052 or 2159 Fax: 762-408-2051**

Patient's Current Name - Printed Date of Birth

Name(s) on previous mammograms (if different than above)

FMP/SSN Patient's SSN Patient's Phone Number

- Is the facility we will get your films from Civilian? _____ Military? _____
- Do you grant us authorization to add other facilities not listed above in order to obtain your mammogram films? Yes _____ No _____
- Is this a **permanent transfer of mammograms** to Martin Army Community Hospital?
Please check one: Yes _____ No _____

Patient's Signature Date

This form was originally signed by the patient and may be photocopied to be sent to multiple facilities.

For office use only:

Facility Phone # _____ Fax # _____

Faxed on _____ Initials _____

Follow-up Phone Call (If needed):
(Date/Time/Contact Name) _____ Initials _____