ZOOM DIAGNOSTIC IMAGING

PATIENT BREAST IMAGING MEDICAL RECORDS REQUEST

Patient Last Name: _____ **First:** _____ **Middle Initial:** _____

Previous Names: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone: _____

records available for pick up/mailing within 15 business days

I request a copy of my breast imaging and reports from (date) _____ to _____.

I would like to receive my images and reports as selected below:

☐ I will pick up my records.

☐ Mail my records to the address above.

☐ Mail my records to:

Name: _____

Address: _____

_____	_____	_____
Signature of Patient or Authorized Legal Representative**	Relationship to Patient	Date

Identification and/or proof of Legal Representative status required

Office Use Only:

Images/Report(s) prepared by: _____ Patient MR#: _____

Images/Report(s) released by: _____ Date Mailed/Picked Up: _____

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