DIAGNOSTIC IMAGING CENTERS, P.A.

Breast Imaging Medical Records Release

Patient Name: _____

MRN: _____ DOB: _____

Exam: _____

Referring Provider: _____

DIC Location: _____ Date: _____

_____

_____

Patient's Prior Last Name (If Applicable): _____ ❑ N/A

Please provide the following information so that we may obtain your latest mammogram and/or other breast imaging records for comparison.

Name of Facility: _____

Address of Facility: _____

City/State/Zip: _____

Phone/Fax: _____

I hereby authorize and request you to release all breast imaging, including copies of reports in your possession to Diagnostic Imaging Centers, P.A.

_____ X_____ _____

Please print name | Patient or authorized signature | Date

REPORTS: Please fax reports to our Medical Records Department at (913) 491-9363.
To reach our Medical Records Staff, please call (913) 327-1771 or (816) 531-1771.

IMAGES: If you are unable to cloud images, please mail CD to our Medical Records department.
Diagnostic Imaging Centers, P.A.
6650 W. 110th St. Suite 100
Overland Park, KS 66211

Thank you!