IMAGECARE RADIOLOGY

PINK BREAST CENTER

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Release of Health Information

To Whom It May Concern:

I, _____ authorize the release of my prior:
(print patient name)

- ☐ CT
- ☐ DEXA
- ☐ MAMMO
- ☐ PET
- ☐ ULTRASOUND
- ☐ MRI
- ☐ X-RAY

records (if available) and applicable reports to ImageCare Radiology.

Patient Signature _____

DOB: _____

PHONE: _____

I authorize a representative of ImageCare will pick up all images (in DICOM format) and reports within 24 hours of receiving this authorization.

Thank you for your kind attention.