WOMAN'S CLINIC
for Breast & Gynecological Care

2424 West Holcombe Blvd. Ste. 102
Houston, TX. 77030
Phone: 832-804-8119
Fax: 832-804-8120

Medical Record Release Form

PRINT NAME:_____

Date of Birth:_____

☐ CD or Films of Mammograms and Breast Ultrasound with reports.

Location of previous Mammogram: _____

Date of previous Mammogram: _____

☐ Biopsy or Surgery Pathology Reports

☐ CD of Breast MRI and Reports

Location of MRI or Breast Biopsy or Surgery: _____

Mail to: Woman's Clinic – Pink Door Imaging
Attn: Mary
2424 West Holcombe Blvd. Ste. 102
Houston, TX. 77030

_____ _____
Patient Signature Date

I am requesting a copy of my **previous mammogram(s) and/or breast ultrasoundimages, and/or other imaging studies** from the above entity for the purpose of comparison to current mammographic studies. As the person signing this consent, I understand that I am giving permission to the above named provider for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included in my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless recipient is a provider who makes disclosures permitted by law. **ATTN: PATIENT'S IF YOUARE REQUESTING FILMS/CD FROM OUR FACITIY, IT CAN TAKE UP TO 48-72 HOURS UPON REQUEST.**