CliniSanitas Medical Center

REQUEST FOR RELEASE OF IMAGES

Date: ____/____/____
mm dd yy

Requested by: **YAHIMA DIAZ** Phone: **(305) 718-9129 or (305) 718-9135**

Patient Name: _____ DOB: ____/____/____
mm dd yy

Provider/Facility: _____ Fax: _____

To whom it may concern:

The patient listed above informed CliniSanitas of a mammogram performed at your facility. In order to complete a comparison and deliver detailed results to the patient, we are requesting this patient's mammography films/results/reports be provided to us in a CD format.

Kindly mail the CD to: **2000 NW 87 Avenue, Doral, FL 33173**
Please mark: **ATTENTION: MAMMOGRAPHY DEPARTMENT / CONFIDENTIAL**

Please contact us at the phone number provided above, in a timely manner, if:
There are any questions or further information is needed.
If there are no records for this patient as this will allow us to request from another facility.
If the CD must be picked and/or it is ready for pick up.

Your prompt attention to this request is greatly appreciated as we are obligated to provide results to the patient within a specific time period.

Thank you in advance for your time in the matter.

CliniSanitas' Mammography Department

_____ Date ____/____/____
Patient's Signature mm dd yy

_____ Date ____/____/____
Technician's Signature mm dd yy