



Hospital/
 Facility Name: _____ Date: _____
 Street: _____ Pt. Name: _____
 City: _____ D.O.B. _____
 State: _____ SS # _____
 Phone: _____ Last Done: _____
 Fax: _____ Other Name(s) Used: _____

PATIENT AUTHORIZATION:

Patient Signature: _____ Date: _____ Time: _____

We would appreciate the loan of any and all original mammography films, CD's and reports on the above patient. This is at the request of our Radiologist for comparison to her most recent films. We will return films to you as soon as they have been reviewed in accordance with MQSA Final regulations 21 CFR 900.12 (cc)(4)(ii)(iii). Please mail them to the address marked below:

- | | | |
|---|--|---|
| <input type="checkbox"/> Kalkaska Memorial Health Center
Women's Imaging Center
419 S. Coral Street
Kalkaska, MI 49646
231-258-7510
Fax: 231- 258-7669 | <input type="checkbox"/> Munson Healthcare Cadillac Hospital
Radiology Department
400 Hobart Street
Cadillac, MI 49601
231-876-7783
Fax: 231-876-6049 | <input type="checkbox"/> Munson Healthcare
Smith Family Breast Health Center
1105 Sixth Street
Traverse City, MI 49684
231-392-7100
Fax: 231-935-0437 |
| <input type="checkbox"/> Paul Oliver Memorial Hospital
Women's Imaging Center
224 Park Avenue
Frankfort, MI 49635
231-352-2225
Fax: 231-352-2222 | <input type="checkbox"/> Munson Healthcare Grayling Hospital
Breast Imaging Department
1100 Michigan Avenue
Grayling, MI 49738
989-348-0350
Fax: 989-348-0426 | <input type="checkbox"/> Munson Healthcare Charlevoix
Breast Imaging Department
14700 Lake Shore Dr.
Charlevoix, MI 49720
231-547-8792
Fax: 231-547-8082 |

By signing above, the patient has authorized your release of past mammography films, CD's and reports to this facility.