REQUEST TO OBTAIN MEDICAL RECORDS

I hereby authorize **Eunice Q. Sorin Women's Diagnostic Center** to obtain the following:
PREVIOUS STUDIES
MOST RECENT 2 YEARS NEEDED
DISCS PREFERRED/FILMS ACCEPTED

- Mammogram films
- Breast ultrasounds
- Breast MRI studies
- Bone Density studies
- Lab results
- Medical reports
- Other information necessary for my medical treatment

From facility:

Facility Name: _____

Street Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

Please fax back if:

_____ No record of this patient _____ No mammo film / sono / reports

Please send to: **Atlantic General Hospital**
Attn: Women's Diagnostic Center
9733 Healthway Drive
Berlin, MD 21811
Phone: 410-641-9215
Fax: 410-641-9036

I authorize the release of my present and prior medical records pertaining to mammograms, breast ultrasound, breast MRI, breast biopsy and lab results and other information necessary for my medical treatment to **Eunice Q. Sorin Women's Diagnostic Center**.

Patient Name:_____ Patient Date of Birth:_____

Patient Signature:_____ Date:_____

ATLANTIC GENERAL HOSPITAL

9733 Healthway Drive
Berlin, MD 21811
Phone: 410-641-9173
Fax: 410-641-9036

Women's Diagnostic Center
Breast Imaging Request
Obtain Health Information