



Mammography Films Request

I hereby request that my most recent Mammography Films be released from:

Facility: _____

Fax: _____

Address: _____

and Sent to:

Virginia Women's Center, Mammography
West End
2240 John Rolfe Parkway
Richmond, VA 23233
Phone (804) 288-4084
Fax (804) 545-9548

Virginia Women's Center, Mammography
Hanover
8266 Atlee Road, Suite 330
Mechanicsville, VA 23116
Phone (804) 288-4084
Fax (804) 559-2046

Virginia Women's Center, Mammography
Henrico
7611 Forest Ave., Suite 200
Richmond, VA 23229
Phone (804) 288-4084
Fax (804) 288-3567

I understand that this authorization will be valid for one year.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Virginia Women's Center has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to Virginia Women's Center at the address checked above.

Patient's Signature _____ Printed Name _____

Date _____ Date of Last Mammography _____

Last four digits of Social Security Number: _____ Date of Birth _____

Reason for Transfer: New Location Appointment Date _____