INNOVACARE LLC
People. Technology. Results.

MEDICAL RECORDS RELEASE

Location of Previous Mammograms: _____

I hereby authorize and request that my **MAMMOGRAMS AND REPORTS** be released to:

Women's Diagnostic Center
Severance Medical Arts Building, Suite 108
5 Severance Circle
Cleveland Heights, Ohio 44118
FAX-216-382-7166

***** Please call us at 216-382-8874 if no films are on file *****

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RELEASE OF MEDICAL INFORMATION

To insure the quality of our services, we recognize the guidelines set forth by the Food and Drug Administration in accordance with the Mammography Quality Standards Act which mandates follow-up on all mammograms needing further evaluation. Should the result of your mammogram suggest further evaluation, your signature will authorize Women's Diagnostic Center to obtain medical/surgical/pathological information and/or medical records as it pertains to the mammogram performed. This information will be kept confidential by Women's Diagnostic Center.

Your signature below authorizes the release of necessary records. This authorization will be valid for one year from the date of signature. A copy of this authorization shall have the same force and effect as the original.

_____

Print Name **Signature**

_____

Date of Birth **Today's Date**