Mammography Record Release Form

Instructions to Patient

Please complete this document and return to us by either:

- **Email:** Elizabeth.Patrick@axiawh.com
- **Fax:** (513) 221-1320
- **Print and Drop Off:** At the Cincinnati Breast Surgeons Red Bank Road Office
- **Mail:**
  Seven Hills Women's Health Centers / CBS
  Attn: Mammography Department
  2060 Reading Road, suite 150
  Cincinnati, OH 45202

We will retrieve your records from your previous facility for you.

Patient Instructions to the Facility

First Name: ______________________ Last Name: ______________________

Previous Last Name - if applicable: ______________________ Date of Birth: __________

I Hereby Authorize:

- ☐ Proscan Imaging/Pink Rribbon Center
- ☐ Mercy Anderson Hospital – Women's Center
- ☐ Mercy West Hospital – Women's Center
- ☐ Mercy Jewish Hospital – Women's Center
- ☐ TriHealth – Mary Jo Cropper Family Center for Breast Care (Bethesda North)
- ☐ TriHealth – McCullough-Hyde Memorial Hospital
- ☐ TriHealth – Good Samaritan Breast Center
- ☐ St. Elizabeth Hospital – Breast Center
- ☐ The Christ Hospital – Comprehensive Breast Center
- ☐ Other: ______________________

Please release my films and reports to:

Cincinnati Breast Surgeons / Anderson Township
7495 State Road, Suite 300
Cincinnati, OH 45255
(Attn: Mammography Department)
PH: (513)-231-3447
Fax: (513)-231-3761

Patient Signature: ______________________

Date: ______________ Patient Phone Number: ______________________

Cincinnati Breast Surgeons Mammography Instructions to Facility

Our patient has requested the transfer of her films and reports to the Cincinnati Breast Surgeons Mammography Center above as soon as possible for patient care purposes. Please notify us immediately if you do not have the requested films and reports.

Thank you,

Cincinnati Breast Surgeons