



Information Request Release

Last Mammogram Facility: _____
City, State: _____
Phone: _____

Patient Information

Name (please print): _____
Previous Last Name (please print): _____
Date of Birth: _____
Telephone Number: _____

Please release my mammography studies in a DICOM format via CD or films to:

Powershare:
Innovative TeleRadiology, Inc.
Fax: (404) 745-8744
Phone: (866) 487-7231

Signature: _____
Date: _____

*** Please call or fax if no mammography studies are available ***

I, do hereby consent and authorize you to release copies of my medical records related to all breast procedures, including current and previous medical records from other practices and practitioners, hospitals, imaging centers, and/or clinics which are a part of my medical records. It may also include information concerning, Cancer, Cancer Testing, and Cancer Results. I agree that a copy of this release or a fax of this release shall be as valid as the original release.