Form # 8638 (03/19)

MUNSON HEALTHCARE

Hospital/
Facility Name: ______________________________ Date: __________________

Street: ______________________________ Pt. Name: ______________________________

City: ______________________________ D.O.B. ______________________________

State: ______________________________ SS # ______________________________

Phone: ______________________________ Last Done: ______________________________

Fax: ______________________________ Other Name(s) Used: ______________________________

PATIENT AUTHORIZATION:

Patient Signature: ______________________________ Date: ________ Time: ________

We would appreciate the loan of any and all original mammography films, CD's and reports on the above patient. This is at the request of our Radiologist for comparison to her most recent films. We will return films to you as soon as they have been reviewed in accordance with MQSA Final regulations 21 CFR 900.12 (cc)(4)(ii)(iii). Please mail them to the address marked below:

☐ **Kalkaska Memorial Health Center**
Women's Imaging Center
419 S. Coral Street
Kalkaska, MI 49646
231-258-7510
Fax: 231- 258-7669

☐ **Munson Healthcare Cadillac Hospital**
Radiology Department
400 Hobart Street
Cadillac, MI 49601
231-876-7260
Fax: 231-876-7855

☐ **Munson Healthcare**
Smith Family Breast Health Center
1105 Sixth Street
Traverse City, MI 49684
231-392-7100
Fax: 231-935-0437

☐ **Paul Oliver Memorial Hospital**
Women's Imaging Center
224 Park Avenue
Frankfort, MI 49635
231-352-2225
Fax: 231-352-2222

☐ **Munson Healthcare Grayling Hospital**
Breast Imaging Department
1100 Michigan Avenue
Grayling, MI 49738
989-348-0350
Fax: 989-348-0426

☐ **Munson Healthcare Charlevoix**
Breast Imaging Department
14700 Lake Shore Dr.
Charlevoix, MI 49720
231-547-8792
Fax: 231-547-8082

By signing above, the patient has authorized your release of past mammography films, CD's and reports to this facility.

MAMMOGRAM FILM RELEASE REQUEST