

Women's Life Imaging Center
200 Route 108, Suite 3 Somersworth, NH 03878
Tel: 603-742-6673 Fax: 603-742-6757

Date of Request: _____
PID # _____

**REQUEST FOR RELEASE OF ALL BREAST IMAGING
ON CD (PREFERRED) OR FILM AND REPORTS**

Patient Name: _____
(Please give name you had at the time films were taken as well as name now)

DOB: _____ Social Security: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

I have an appointment at Women's Life on: _____

I am requesting all of my original Breast Imaging
CD (Preferred) or FILMS and Reports be sent to:

**Women's Life Imaging Center
200 Route 108, Suite 3
Somersworth, NH 03878**

It is my request that Breast Imaging CD/Films be:

- TEMPORARY RELEASE:** Breast Imaging films/cd will be returned to sending facility upon completion of the exam comparison.
- PERMANENT RELEASE:** Breast Imaging films/cd will be stored at Women's Life Imaging and not returned to the sending facility.

PATIENT SIGNATURE

DATE

WLIC called / sent / faxed for films/cd on _____ Initials: _____
_____ Initials _____