



# Eunice Q. Sorin Women's Diagnostic Center

## REQUEST TO OBTAIN MEDICAL RECORDS

I hereby authorize Eunice Q. Sorin Women's Diagnostic Center to obtain the following:  
PREVIOUS STUDIES  
MOST RECENT 2 YEARS NEEDED  
ON A DISC OR POWERSHARE IF CAPABLE

- Mammogram films
- Breast ultrasounds
- Breast MRI studies
- Bone Density studies
- Lab results
- Medical reports
- Other information necessary for my medical treatment

From facility:

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

Please fax back if:


\_\_\_\_\_ No record of this patient                      \_\_\_\_\_ No mammo film / sono / reports

**Please send to: Atlantic General Hospital**  
 Attn: Women's Diagnostic Center  
 9733 Healthway Drive  
 Berlin, MD 21811  
 Phone: 410-641-9215 | Fax: 410-641-9036

I authorize the release of my present and prior medical records pertaining to mammograms, breast ultrasound, breast MRI, breast biopsy and lab results and other information necessary for my medical treatment to Eunice Q. Sorin Women's Diagnostic Center for continuum of care.

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 <p>9733 Healthway Drive        Berlin, MD 21811        Phone: 410-641-9173        Fax: 410-641-9036</p>	<p>Women's Diagnostic Center        Breast Imaging Request        Obtain Health Information</p>
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