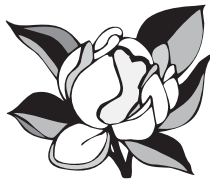


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Phone: (850) 878-6104

Fax: (850) 309-0650

Date: \_\_\_\_\_

Facility of Previous Mammogram: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Last Mammogram: \_\_\_\_\_

Referring Physician for Last Mammogram: \_\_\_\_\_

I hereby authorize you to release mammogram films and report needed for comparison purposes to:

The Women's Imaging Center  
1600 Phillips Road  
Tallahassee, Florida 32308

Patient's Name: \_\_\_\_\_

Patient's Previous Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

If military base:

Spouse Name: \_\_\_\_\_ SS#: \_\_\_\_\_

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