Authorization For Release Of Mammogram/Ultrasound Images

Date: _____

☐ My previous Mammogram was done at Aylo Health Imaging Center

☐ My previous Mammogram was NOT done at Aylo Health Imaging Center

Facility of Previous Mammogram Films:

Facility Name: _____

Street Address: _____

CITY STATE ZIP CODE

Phone: _____ Fax: _____

Last name at time of previous mammogram: _____

***Please note, your exam will be held for 14 days prior to being read by the radiologists. Aylo Health will make all attempts to acquire previous mammogram films for comparison.**

I hereby authorize the practitioner of the facility listed above to release my **mammogram/breast ultrasound films/Pathology results** to

Aylo Health
Imaging at Stockbridge
1100 Hospital Drive
Stockbridge, GA 30281

Phone: 678-432-6161 Ext. 13144 **Fax:** 678-432-3677

This authorization is valid from the date of my or my representative's signature below and shall expire in 366 days unless otherwise noted by me or my representative.

PATIENT NAME _____ DATE OF BIRTH _____

SIGNATURE OF PATIENT _____ DATE _____

NAME OF REP. _____ SIGNATURE _____ DATE _____

Releasing facility: please fax this form to Aylo Health, Imaging Services.

Images PowerShared on: _____ Films/Images on CD/DVD Mailed on: _____ No record in our system - Initial _____