HOUSTON Methodist WEST HOSPITAL

Breast Center - Patient Consent for Use and Disclosure of Protected Health Information

Request for Patient Records

Patient Name: _____Date of Birth: _____

I authorize: _____to release **ALL BREAST IMAGING & REPORTS.**

(Place where your last mammogram was done.)

ALL BREAST IMAGING & REPORTS MUST BE MAILED TO:

Houston Methodist West Hospital – Breast Care Center

18500 Katy Freeway

Houston, Texas 77094

Patient Signature: _____Date: _____

Below is for Houston Methodist West Hospital staff to fill out:

Date:

To:

Fax:

☐ **Please send all prior breast imaging studies and reports for comparison**

☐ **Films or CD's in Dicom format are ok**

☐ If you are unable to locate records for this patient, please check this box and ***fax*** this form back to ***832-522-1031***. You can also contact the Breast Center at 832-522-1020