FILM REQUEST

PLEASE SEND ONLY THE LAST 2 YEARS OF FILMS & REPORTS
CD'S ARE ACCEPTABLE

Patient Name ______________________________

Date of Birth ______________________________

JMC MRN#: _______________________________

Name of Facility ____

Phone Number ____

Fax Number ____

Please release to JUPITER MEDICAL CENTER—Margaret W. Niedland Breast Center/Wellness in Motion Bus the following for the purpose of comparison:

MAMMOGRAM and/or BREAST ULTRASOUND IMAGES

This consent will expire ninety days after the date signed or sooner at my election. To revoke my consent, I must deliver written notice to the information source.

___________________________________ ___________________
Patient Signature Date

____
Relationship, if not patient

Mail films to: Jupiter Medical Center
Radiology Department
1210 S Old Dixie Hwy
Jupiter, Florida 33458
Ph: 561-263-4411 Fax: 561-263-4420