



**Mammography Department**  
340 NE Commerce Dr.  
Lake City, FL 32055  
(386) 755-0180 - Phone  
(386) 755-0690 - Fax

**Facility or Physician Name:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

**Mammograms**

**Ultrasounds**

**Reports/Results**

**I hereby authorize the release of my mammograms, breast ultrasounds and any/all reports relating to any follow up procedure performed due to the result of my mammogram done at LCMC i.e. surgical / pathology reports.**

**Patient Signature:** \_\_\_\_\_

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

**Witness Signature:** \_\_\_\_\_