



## Request for Image(s)/Report(s) Release

Name of Facility to Release Records: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please release my Mammogram / MRI / CT / Ultrasound / X-Ray CD/films and related report(s) to:  
(Please circle all applicable modalities.)

**Please provide all digital images on CD.**

***Invision Sally Jobe at The Centrum DTC  
 Attention: Medical Records  
 8200 E. Belleview Avenue, Suite 200E  
 Greenwood Village, CO 80111  
 Phone: 720/493-3270  
 Fax: 720/493-3280***

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

Date of Birth: \_\_\_\_\_ MRN: \_\_\_\_\_

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

This request is in keeping with the **MQSA/FDA** guideline **CFR 900.12(c)(4)(H)** stating (THE FACILITY) shall upon request by, or on behalf of, the patient's, permanently or temporarily transfer the original mammograms and copies of the patient's reports to a medical institution, or to a physician or health care provider of the patient, or to the patient directly; **CFR 900.12 (c)(4)(iii)** Any fee charged to the patients for providing the services in paragraph (c)(4)(H) of this section shall not exceed the documented costs associated with this service.

Internal Use			
Date/Time	Faxed to Lending Facility	Scanned	Emailed
Initials			