FOX CHASE
CANCER CENTER

333 Cottman Avenue
Philadelphia, PA 19111-2497

Authorization To Release Mammography Films

To: The Radiology Film Library at:

________________________________ ________________________
Medical Facility **Phone Number**

________________________________ ________________________
Street Address **Fax Number**

____
City **State** **Zip**

Please mail my mammography films to:

Fox Chase Cancer Center
Mammography Department
Attention: Tina Donahoe
333 Cottman Avenue
Philadelphia, PA 19111-2497
Phone Number – 215.728.7046 Fax Number – 215.728.1185
215.728.2646

________________________________ ________________________`
Name - Signature * **Social Security Number**

________________________________ ________________________
Name - Please Print **Date of Birth**

________________________________ ________________________
Address **Today's Date**

________________________________ **BSA&I 4-23-07**
City **State** **Zip** **Corporation**

(*By signing this Authorization form, you are giving permission to Fox Chase Cancer Center to request and receive your previous mammography films from the medical facility you listed above).

Sent By: ________________________________