BaylorScott&White
MEDICAL CENTER
LAKE POINTE
Joint ownership with physicians

REQUEST TO OBTAIN MEDICAL RECORDS

I hereby authorize **BAYLOR SCOTT & WHITE BREAST CENTER** to obtain the following:

PREVIOUS STUDIES:

- Mammogram films
- Breast Ultrasounds
- Breast MRI studies
- Lab results
- Medical reports
- Other information necessary for my medical treatment

FILMS PREFERRED / DISCS ACCEPTED

From facility:

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Please fax back if:

______No record of this patient

______No mammo film/sono/reports

Please send to:

Baylor Scott & White Breast Center
1005 W. Ralph Hall Parkway, Suite 121
Rockwall, TX 75032
469.698.8555 PHONE
469.698.8551 FAX

Patient name: ____

Patient signature: ____

Patient Date of Birth: ______________________ Date: ______________________