NORTH MISSISSIPPI
MEDICAL CENTER
BREAST CARE CENTER

Name _____
(Last) (First) (MI)

Has your name changed since last mammogram? _____

Birthday _____/_____/_____ Age _____

S.S. # _____/_____/_____ Phone # (___)_____-____

Street Address _____

City _____ State _____ Zip _____

The undersigned hereby authorizes and requests

_____

_____

_____

The ordering physician for the mammogram was:

_____

to provide the Breast Care Center, Tupelo, Miss., with the access to my medical/hospital records for the purpose of review and examination and further authorizes and requests that you provide such copies thereof as may be requested.

Original Mammogram film for the time period from _____ to _____

Permanent mammography films transfer: _____ (Initial)

Signature: _____ Date: _____
(If signed by personal representative, state relationship and authority to do so)

Any disclosure of Medical Records information by the recipient(s) is prohibited except when implicit in the purpose of this disclosure.