

## **Mammography Record Release Form**

## Instructions to Patient

Please complete this document and return to us by either:

- Email: Mammo-7Hills@axiawh.com
- Fax: 513-639-3186
- Print and Drop Off: At your Seven Hills care center
- Mail:
   Seven Hills Woman's Health Centers
   Attn: Mammography Department
   2060 Reading Road, suite 150
   Cincinnati, OH 45202

We will retrieve your records from your previous facility for you.

Patient Instructions to the Facil	ity	
First Name:	Last Name:	
Previous Last Name - if applicable:		Date of Birth:
l Hereby Authorize:		
Proscan Imaging/Pink Rribbon Center		
Mercy Anderson Hospital – Women's C	enter	
Mercy West Hospital – Women's Center		
Mercy Jewish Hospital – Women's Cent		
Trihealth – Mary Jo Cropper Family Cer		
Trihealth - Good Samaritan Breast Cent		
St. Elizabeth Hospital- Breast Center	ei	
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The Christ Hospital – Comprehensive B		
Other:		
Please release my films and reports to Seve	n Hills Women's Health Centers: (select the locatio	on your screening mammogram is scheduled)
Ohio: Anderson Township	Ohio: Westfork Road	☐ Kentucky: Turfway
7495 State Road, Suite 300	3747 West Fork Road	6901 Burlington Pike
Cincinnati, OH 45255	Cincinnati, OH 45247	Florence, KY 41042
(Attn: Mammography Department) PH: (513) 231-3447	(Attn: Mammography Department) PH: (513) 481-4777	(Attn: Mammography Department) PH: (859) 282-6700
Fax: (513) 231-3761	Fax: (513) 389-0473	Fax: (859) 282-6760
Patient Signature:		
Date:	Patient Phone Number:	

## Seven Hills Women's Health Centers Mammography Instructions to Facility

Our patient has requested the transfer of her films and reports to the Seven Hills Women's Health Center above as soon as possible for patient care purposes. Please notify us immediately if you do not have the requested films and reports.

Thank you,

Seven Hills Women's Health