University of Cincinnati Medical Center | UC Health

Request for Comparison Images

Name (please print): _____ **Birthdate**: _____

Previous Last Name: _____ MRN (staff use only): _____

(**VA** PATIENTS ONLY) SS# _____ (LAST 4 DIGITS)

A. ☐ **The past 4 mammograms have all be at UC Medical Center**
(includes Barrett Cancer Center/Medical Arts Building)

Or

B. ☐ If you had mammograms here and at other locations, please list on each line where you had your **LAST 4 mammograms**.

Name of Hospital/Breast Center	**City, State**	**Location**	**Year**

Consent for Release of Records: I authorize institutions or physicians with who I previously received treatment to release information to the Breast Imaging Center and/or its physicians. **Examples of this information would include previous mammography reports, films and/or DICOM Digital images on CD and pathology results to the address listed below.** I also authorize the release of medical information to the physicians or agencies responsible for my follow-up care. **I HAVE READ AND UNDERSTAND THIS CONSENT FOR RELEASE OF RECORDS**.

Signature: _____ Date: _____

Send to: **University of Cincinnati Medical Center**
Barrett Center – Breast Imaging Department
234 Goodman St. ML: 0772 – 3rd Floor
Cincinnati, OH 45219-2316
Phone: (513) 584-0989 Fax: (513) 584-3633

PLEASE SEND DIGITAL IMAGES ON (DICOM) CD & WRITTEN REPORTS