



DATE: _____

REQUEST TO OBTAIN MEDICAL RECORDS

I hereby authorize **ELIZABETH JEKOT MD BREAST IMAGING CENTER** to obtain the following:

PREVIOUS STUDIES
MOST RECENT 2 YEARS NEEDED
DISCS PREFERRED/FILMS ACCEPTED

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

From facility: _____

Please fax back if:

_____ No record of this patient

_____ No mammo film / sono / reports

Please send to: ELIZABETH JEKOT MD BREAST IMAGING CENTER

Attn: Medical Records 214-442-7050 phone
3301 East Renner Road, Suite 100 214-442-7075 fax
Richardson, Texas 75082

I authorize the release of my present and prior medical records pertaining to mammograms, breast ultrasound, breast MRI, breast biopsy and lab results and other information necessary for my medical treatment to Elizabeth Jekot, MD Breast Imaging Center.

Patient Name: _____

Patient Signature: _____

Patient Date of Birth: _____