

The Women's Center at Prestonwood  
6957 W. Plano Pkwy. Suite 1400  
Plano, TX 75093  
PH: 972-820-8774 FAX: 972-820-8718

**MAMMOGRAPHY CONSENT FORM / RELEASE OF FILMS**

**PERSONAL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**ORDERING PHYSICIAN INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

By signing this form, you authorize employees, including physicians, physician's assistants and nurse practitioners, imaging technologists, including consultants, associates, and assistants of the physicians' choice to coordinate your care.

You understand that you are responsible for the total charges for services rendered which may include services not covered by your insurance companies. You agree that all amounts are due upon request and are payable to Prestonwood Imaging. You further understand should your account become delinquent, you shall pay the reasonable attorney fees or collection expenses of Prestonwood Imaging, if any. By signing this form, you consent to Prestonwood Imaging release and/or disclosure of your medical information for treatment, payments, health care operations, and as otherwise allowed by law. This includes any medical service or visit, Diagnostic testing ordered by the physician or the physician's staff. The duration of this consent is indefinite and continues until revoked in writing.

**AUTHORIZATION TO OBTAIN PRIOR MAMMOGRAPHY STUDIES/REPORTS**

I AUTHORIZE \_\_\_\_\_ TO RELEASE MY  
*NAME OF PREVIOUS FACILITY*

MAMMOGRAPHY FILMS TO THE WOMEN'S CENTER AT PRESTONWOOD.

PRIOR MAMMOGRAM DONE ON: \_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(Signature of Patient or Legal Representative)

\_\_\_\_\_  
(Date)