SONOCARE
DIGITAL MAMMOGRAPHY

INFORMATION REQUEST RELEASE

Date: _____/_____/_____

Facility Where Last Mammogram Performed:

_____ City:_____

Patient Information:

Name: _____ Previous Last Name: _____

Date of Birth: _____/_____/_____ SSN: _____ - _____ - _____

Address: _____

_____

Telephone Number: (_____) _____ - _____

Please Release My Mammography Studies On CD To:

SonoCare, LLC
125 B Wamsutta Mill Rd.
Morganton, NC 28655

p. (828) 430-3511
f. (828) 430-3513

Signature: _____ Date: _____