O'SULLIVAN RADIOLOGY

Breast, Bone & Body Digital Imaging
6915 N. Main St., Victoria, Texas 77904
361-572-3139 fax 361-572-8610

1. ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

2. RELEASE OF MEDICAL REPORTS AND X-RAYS

I consent to the release of medical records, reports, and x-rays from other facilities to O'Sullivan Radiology for the purpose of the radiologist's comparison review with my current exams performed at O'Sullivan Radiology.

Patient's Name:____

SS#: ______________________ Birthdate: ______________________

______________________ ______________________
Signature of Patient or Patient's Authorized Representative Date Signed

For Office Use Only:

REPORTS AND X-RAYS REQUESTED (Previous Two Years)

Mammogram Bone Density X-Rays Ultrasound Pathology

I request and authorize ____
(Name of Hospital or Facility)

ADDRESS: ______________________ PHONE: ______________________

FAX: ______________________

Please release the requested x-rays and reports of the patient named above to:

O'Sullivan Radiology
6915 N. Main St.
Victoria TX, 77904

Thank you for your prompt response to our request. Have a happy day!