River Forest Medical Campus

420 William St. River Forest IL 60305
Tel: 708-763-4728 Fax: 708-763-2020

REQUEST FOR ORIGINAL MAMMOGRAMS

I, _____ Date of Birth: _____ request the River

Forest Breast Care Center to release my original mammograms which were performed on _____ at
Westlake Hospital. (Date)

*****Copies of films and CD's DO NOT have to be returned*****

The following statement pertains to original analog film requests only:

I understand the mammograms are the property of the River Forest Breast Care Center and are on loan to me. **I agree to return them to the River Forest Breast Care Center within 90-days of the date I received them**. I understand to indemnify, reimburse and hold harmless the River Forest Breast Care Center from any and every cost, expense, loss of fee, including but not limited to attorney(s) fees, incurred as a result of failure to return the mammograms as agreed.

Send Records to [or] self pick up:

Records taken to: _____

_____

_____

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Witness) (Date)

_____
Person authorized to receive records (if other than patient, please print)

_____ _____
Signature of person receiving records (*if other than patient and if not mailed*) (Date)

ID-Identified (initials) _____ ☐ Yes ☐ No

RETURNED:

Released By: _____

DATE REQUESTED: _____

NUMBER OF MAMMOGRAM FILMS: _____

NUMBER OF U/S FILMS: _____

NAME AND NUMBER OF OUTSIDE FILMS _____

RECEIVED BY: _____

DATE: _____

NUMBER OF MAMMOGRAM FILMS: _____

NUMBER OF U/S FILMS: _____

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