The Center for Women's Health
COASTAL IMAGING LLC

Patient Name: ______________________________ **Date of Birth:** ____________________

Maiden or Previous Name(s): ____________________

I hereby authorize Coastal Imaging and The Center for Women's Health to obtain medical records, including images and reports from the named facility below:

Prior Imaging Facility:

Facility Name: ____

Facility Address: ______________________________________

City: __________________ State: ____________ Zip: ____________

Exams Requested for Comparison Purpose (continuation of care):

☐ Mammograms ☐ Breast Biopsies ☐ Breast Ultrasound ☐ Breast MRI ☐ Other: ______________

Share with us electronically via PowerShare:
Account Name: Coastal Imaging

Send us a DICOM Formatted CD:
The Center for Women's Health
105 Grand Central Blvd., Ste. 106
Pooler, GA 31322

Fax us Reports:
(912)303-5471

Please call (912)355-6255, ext. 1501 if:

- Patient has had an exam but not images are available
- There is no record of breast imaging for this patient

____ ______________________________

Signature of Patient/Patient Representative **Date**

Office Use Only

Facility Phone: ________________________

Facility Fax: ________________________

Attention: ________________________