



**Rutland Regional
Medical Center
Diagnostic Imaging**
160 Allen Street
Rutland, VT 05701
(802) 747-1755 Fax: (802) 747-6200

RECORDS RELEASE AUTHORITY

DATE _____

I, _____
Patient's Name

Authorize _____
Institution name, address, & phone number

TO RELEASE MY X-RAYS TO: RRM
Mammography Department
Diagnostic Imaging
160 Allen Street
Rutland, VT 05701
Attention: Pam Jackson

Temporary film transfer _____
patient's signature

OR

Permanent film transfer _____
patient's signature

Patient's Name (printed) and DOB _____

Patient's Address _____

Request for _____
Exam and Date of Exam

Witness _____