Your Hospital's Logo Here

PATIENT CONSENT FORM

MAMMOGRAM

Wellness Institute & Mammography Center
Street Address City, State Zip (202) 555 - 1212

I understand *(check one)* **:**

☐ That this is a **SCREENING** mammogram. I will receive a letter stating the results and recommended follow up within 2 weeks. If I do not receive a letter, it is my responsibility to contact the Mammography Center at (202) 555 - 1212. It is also my responsibility to contact my physician for further explanation.

Results of my mammogram should be sent to:

PHYSICIAN _____ TELEPHONE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

☐ That this is a **DIAGNOSTIC** mammogram. It is my responsibility to contact my physician for the results and recommended follow-up.

I ACKNOWLEDGE that I have read and understand the above statement; have correctly listed my physician information; and, have received the booklet which provides more detailed information.

PATIENT SIGNATURE:	DATE:

PART OF THE MEDICAL RECORD