ROSETTA
advanced imaging • radiation oncology
diagnostic radiology • women's imaging
1421 Third Avenue
New York, NY 10028
212-744-5538
Fax: 212-744-4767
www.rosettaradiology.com

Medical Record Request

Patient Name: _____ Date of Birth: _____

I request and authorize Rosetta Radiology to release my medical records to the following address,

Name: _____

Address: _____ Suite/Room/Floor: _____

City: _____ State: _____ Zip Code: _____

Please Check off which tests you would like to be sent and the type of exam (e.g. pelvic, breast, abdominal) on the blank space next to the test.

Mammogram		
X-Ray	_____	Date: _____
Sonogram	_____	Date: _____
MRI	_____	Date: _____
CT	_____	Date: _____
Bone Density		
Submitted Films/CD's		

Specify the dates of your exam (If you cannot recall the exact dates, just state the year(s).

***Please note* unless your doctor specifically requests films or if you are requesting images from before July 2008, All images are put onto a DICOM CD and all reports are automatically included with the images.**

Patient Signature: _____

Date: _____

It may take 3-5 business days for you to receive the images.

Please email this form to MedicalRecords@rosettaradiology.com or fax it to (212) 570-1580