breastlink NEW YORK

Outside Physician Information Sheet

Patient's Name: _____ Date of Birth: _____

Patient's Signature: _____Date: _____

Please indicate below all of the physicians who you would like to receive information by mail regarding any exams and/or consultations which you have had at our facility. Please indicate whether the physician is your primary care physician, OB/GYN, surgeon, or another specialist. In order to assist in sending your other physicians updated copies of your records, please provide as much information as possible.

Referring Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

Primary Care Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

Other Physician's to receive copy of medical record

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____