Date: [Insert Date]

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Patient ID: [Insert Patient ID]

To Whom It May Concern,

This letter serves to confirm that [Patient Name] has undergone a clinical evaluation and is cleared to proceed with her **Annual Preventive Screening Mammogram**.

Based on the patient's medical history and current physical assessment, there are no contraindications to performing this routine screening. This procedure is recommended as part of the patient's preventive healthcare maintenance plan.

Procedure Requested: Screening Mammogram (Bilateral)
Diagnosis Code: Z12.31 (Encounter for screening mammogram for malignant neoplasm of breast)

Should you require any additional information or clinical documentation, please contact our office at [Insert Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice/Clinic Name]
[Practice Address]
[NPI Number]