

Date: [Insert Date]

To: [Radiology Department/Facility Name]

Address: [Facility Address]

Phone/Fax: [Facility Phone/Fax Number]

RE: Request for Radiology Images and Reports

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Patient ID/MRN: [Patient ID Number]

To Whom It May Concern,

Our clinic is currently providing oncological care for the above-mentioned patient. To assist with their treatment planning and clinical evaluation, we kindly request the release of the following diagnostic records:

- **Type of Exam(s):** [e.g., CT Chest/Abdomen/Pelvis, PET/CT, MRI Brain]
- **Date of Exam(s):** [Insert Dates or Range]
- **Required Materials:** DICOM Images (on CD or via electronic transfer) and formal Radiologist Reports.

Please send these records via the following method:

Electronic Upload: [Insert Link or Portal Name]

Fax Reports to: [Insert Fax Number]

Mail CD to:

[Oncology Clinic Name]

Attn: [Physician Name or Department]

[Clinic Address]

[City, State, Zip Code]

A signed patient authorization for the release of medical information is attached to this request. If there are any questions, please contact our office at [Clinic Phone Number].

Thank you for your prompt assistance in this matter.

Sincerely,

[Signature]

[Printed Name of Requesting Physician/Provider]

[Oncology Clinic Name]