

Account # _____

24411 Health Center Dr. #200C, Laguna Hills, CA 92653 * Phone#: 949-829-5500 ext. 37350
Fax#: 949-581-9158 * Email: mammography@ocwmg.com



AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR MAMMOGRAPHY TO OCWMG

1. Please **OBTAIN** my medical information from:

Hoag	949-451-6000	949-764-8237
Name of Physician, Hospital, or Self	Phone#	Fax#
1 Hoag Drive	Newport Beach	CA
Address	City	State
		92663
		Zip

2. **Patient Information:**

Print Patient Name	(Other names used/AKA)	Date of Birth
Street Address	City	State
		Zip
Phone #	Fax #	Email Address

3. **Purpose for Records Request:** Mammography continuity of care

4. **Please specify records to be disclosed ***:**

Last 3 Mammography films and reports

Date: _____ Signature: _____ Print Name: _____

Please mail