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 <u>OBTAIN</u> my medical information from**:

Memorial Care Imaging Center- San Clemente	**949-493-8799**	**949-493-2645**
Name of Physician, Hospital, or Self	Phone#	Fax#

675 Camino De Los Mares	**San Clemente**	**CA**	**92673**
Address	City	State	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**: <u>Mammography continuity of care</u>

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

☒ Last 3 Mammography films and reports

Date: _____ Signature: _____ Print Name: _____