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

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

____

Name of Physician, Hospital, or Self **Phone#** **Fax#**

____

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**: Mammography continuity of care

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

☒ Last 3 Mammography films and reports

Date: ____________ Signature: ______________________________ Print Name: ______________________