

Account # _____

24411 Health Center Dr. #200C, Laguna Hills, CA 92653 * Phone#: 949-829-5500 ext. 102
Fax#: 949-581-9158 * Email: mammography@ocwmg.com



AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR MAMMOGRAPHY TO OCWMG

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

MemorialCare Breast Center **949-452-7200** **949-380-4550**

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

24401 Calle de la Louisa, Suite 200 **Laguna Hills** **CA** **92653**

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: _____

For courier pick up only