

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:

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: Mammography continuity of care

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

Last 3 Mammography films and reports

Date: _____ Signature: _____ Print Name: _____