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**:

Mission Hospital	**949-364-1400**	**949-365-3889**
Name of Physician, Hospital, or Self	Phone#	Fax#

26732 Crown Valley Parkway	**Mission Viejo**	**CA**	**92691**
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: ______________________

☒ Please mail