Account # _____

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

ORANGE COAST WOMEN'S MEDICAL GROUP

AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR MAMMOGRAPHY

1. **Please <u>OBTAIN</u> 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**: <u>Mammography continuity of care</u>

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

☒ Last 3 Mammography films and reports

Date: _____ Signature: _____ Print Name: _____