Women's Imaging Center
Trico Sycamore Plaza Medical Office Building
431 S. Batavia St., Suite 100
Orange, CA 92868

Phone: 714-771-8360
Fax: 714-771-8364

Authorization of Release of Medical Records

Date of request: ______________________________

Patient Name: ______________________________ DOB: ____/____/______
(last) (first) (m.i.) MM DD YYYY

Address: ______________________________
(address) (city) (state) (zip code)

Phone: ______________________________ Patient ID: ______________

I hereby authorize [Women's Imaging Center] to release my medical records to:

- ☐ **Self**
- ☐ **Physician or health care provider:**

Name: ______________________________

Address: ______________________________
(address) (city) (state) (zip code)

Phone: ______________________________

- ☐ **Another party (Please provide name):** ______________________________

Requested medical records **(please circle):** ☐ Report only ☐ Report + Film

Description of exam(s) **(please circle):** ☐ X-Ray ☐ Ultrasound ☐ DXA ☐ Mammography

Date(s) of exam(s): ______________________________

By signing below, I understand that this authorization will become effective as of the date signed, and that I may revoke the authorization at any time. I accept full responsibility for the records I receive, or for my records picked up by another party at my request.

______________________________ ______________

Signature of patient or authorized representative: **Date**

FOR OFFICE USE ONLY

Date medical records issued: ______________________________

Signature of person picking up records: ______________________ Date: ____________

Driver's license verified ☐ Other picture identification verified ☐ Type: ______________

Staff member's signature: ______________________________