



24301 Paseo De Valencia, #100  
Laguna Woods, CA 92637

Office Use Only  
MRN \_\_\_\_\_  
BIRAD \_\_\_\_\_

**AUTHORIZATION TO RELEASE  
PRIOR BREAST IMAGING RECORDS  
(Mammograms, Ultrasound, MRI)**

Patient Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_\_  
*Please Print Clearly*

**I hereby authorize facility checked below to release all prior breast imaging to:**

Orange County Diagnostics  
24301 Paseo De Valencia, #100  
Laguna Woods, CA 92637

Phone: (949) 859-0400 Fax: (949) 859-0414

- Anaheim Memorial Medical Center (714) 999-6007
- Breast Clinic for Early Diagnosis, off Greenfield (LN) (949) 831-4927
- Bristol Park Medical Group, Fountain Valley (714) 433-3100
- Bristol Park Medical Group, Mission Viejo (949) 367-5200
- Hoag, Aliso Viejo (949) 425-1779
- Hoag, Huntington Beach (714) 968-7235
- Hoag, Irvine (949) 764-5861
- Hoag, Newport Beach (949) 764-5861
- Irvine Digital Mammography, (Women's Medical Group Irvine) (949) 721-1206
- Kaiser, Anaheim (714) 284-4408
- Long Beach Memorial Medical Center (562) 933-7810
- Mission Breast Care Center, Mission Viejo (949) 364-0442
- Moran, Rowen, & Dorsey, Orange (714) 771-8364
- Newport Diagnostic Center, Newport Beach (949) 720-3944
- Newport Imaging Center, Newport Beach ( San Miguel Dr) (949) 721-1206
- Ocean View Diagnostic Imaging (RMG), San Clemente (949) 493-2645
- Orange Advanced Imaging, Orange (714) 978-7325
- Orange Coast Memorial Medical Center (714) 734-5079
- Saddleback Memorial Breast Care (Behind Laguna Hills Mall) (949) 460-9719
- Scripps Polster Breast Care Center, La Jolla (858) 626-5233
- South Coast Health Center, Aliso Viejo (949) 499-7238
- South Coast Medical, South Laguna (949) 499-7238
- St Joseph Hospital, Orange (714) 744-8507
- St Jude Breast Center, Fullerton (714) 446-5434
- UCI Imaging Center, Irvine (714) 456-8907
- West Coast Radiology, (Second Floor Irvine Medical Center-Irvine) (949) 753-9030
- West Coast Breast Radiology, Santa Ana (714) 285-1293
- West Coast Radiology, Laguna Niguel (714) 285-1293
- Other: \_\_\_\_\_

Records obtained in the course of my diagnosis and treatment at facility above, specifically;  
I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization. I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information.

Signature of patient/parent/guardian: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_\_

*For Office Use Only*

Fax Attempts:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_