alinea | MEDICAL IMAGING

MEDICAL RELEASE

CONTACT: (909) 622-3166

Patient Name: _____ Date: _____

Address: _____ DOB: _____

City, St, Zip: _____ Phone: ( ) _____

BREAST IMAGING (MAMMOGRAM, BREAST ULTRASOUND, OR BREAST MRI)

RELEASE FROM:

Facility Name: _____

Address: _____

City, St Zip: _____

Phone: ( ) _____ Fax: ( ) _____

IMAGE TYPE

☐ Images CD

☐ Printed Film

RELEASE OF MEDICAL RECORDS:

I hereby authorize and request you to release all breast imaging medical records, including copies of reports in your possession to Alinea Medical Imaging.

X: _____ **Date:** _____

☐ Patient ☐ Other/Relationship: _____

PLEASE RELEASE MEDICAL RECORDS TO:

ALINEA MEDICAL IMAGING

2475 N GAREY AVE,
POMONA, CA 91767

Phone: (909) 622-3166

Fax: (909) 622-8046