MEMORIALCARE IMAGING CENTER
San Clemente

Patient Medical Records Access, Release and Authorization Form

Patient Name: _____ DOB: _____ Phone #:_____

Patient Address: _____

Medical Record #: _____ DOS: _____

Type of Record Requested: _____

☐ Patient requesting records to be mailed. Charges for 2nd set of records: ***Film - $25 per sheet CD - $25 per CD***

Records will be delivered by U.S. Postal Service to the address noted above. Records will not be faxed or e-mailed to the patient.

☐Patient requesting records to be forwarded directly to a Medical Facility or Physician.
Please provide the Medical Facility or Physician information below:

Name: _____

Address: _____

☐ MemorialCare Imaging Center – San Clemente is requesting records to be forwarded directly to us.

The above patient is receiving care at MCICSC and in accordance with Federal and State Law has electronically acknowledged receipt of our Notice of Privacy Practices, which authorizes MCICSC to obtain outside medical records to enable us to complete our health care delivery. Please mail the requested medical records to:

MemorialCare Imaging Center – San Clemente
675 Camino de los Mares, Suite 101
San Clemente, CA 92673
Ph: 949.493.8799 Fax: 949.493.2645

☐ Patient is a minor ☐Patient unable to sign because: _____

Signer is: ☐Patient ☐Father ☐Mother ☐Other Legal Guardian
☐Conservator of an incompetent patient
☐Beneficiary or personal representative of deceased patient

Signature: _____ **Date:** _____
Witness:
_____ **Date:** _____

Patient – you have the legal right to have a copy of this authorization. Would you like a copy? ☐ Yes ☐ No

MemorialCare Imaging Center, San Clemente is hereby released from all legal liability that may arise from the release of this information by the party named above.

Signature of Authorized MCICSC Medical Records _____ **Date:** _____