



**NEWPORT  
IMAGING  
CENTER**

## Medical Records Request

This authorization for disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 et seq.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize:

Name of Physician, Facility or Person; \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To release my records pertaining to : \_\_\_\_\_

**TO  
Newport Imaging Center  
360 San Miguel Road #106  
Newport Beach, CA 92660  
PH# 949-721-8191 FAX 949-721-1206**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by other than the patient, indicate relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_