



WCRC

West Coast Radiology Centers

Capability. Convenience. Service.

Consent to Obtain Medical Records

Date: _____

Patient: _____

Date of Birth: _____

Scope of Access Requested

All Records

Records Pertaining To: _____

I, (Patient name) , _____ hereby request my films and reports to be

released to:

West Coast Radiology Center

West Coast Breast Center

(Mammography Only:)

Permanent Transfer

Temporary Transfer

I hereby release you from all legal responsibility or liability that may arise from this request.

Signature of responsible party: _____ Date: _____

Signature of patient, legal guardian or conservator giving consent.

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

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