AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, (DOB): _____

Hereby authorize: _____

Phone Number: _____ Fax Number: _____

To release my medical records to:

☐ ProHealth Advanced Imaging Medical Group, Inc.

7345 Medical Center Drive Suite 130 West Hills, CA 91307 P: 818-710-6011 F: 818-710-6311

☐ ProHealth Advanced Imaging Medical Group, Inc.

10767 Riverside Drive North Hollywood, CA 91602 P: 818-301-6700 F: 818-301-6701

☐ Beverly Hills Imaging Medical Center

145 South Doheny Drive Beverly Hills, CA 90211 P: 310-550-5858 F: 310-550-5775

☐ University Imaging Center

14915 Burbank Blvd Sherman Oaks, CA 91411 P: 818-909-7111 F: 818-909-6767

☐ University Imaging Center

18388 Clark St #115 Tarzana, CA 91356 P: 818-609-0911 F: 818-609-0229

THE FOLLOWING EXAM IS NEEDED:

☐ **CT**
☐ **MRI**
☐ **US**
☐ **X-RAY**

FOR DATE OF SERVICE: _____

_____☐_____ REPORTS _____☐_____ FILMS _____☐_____ BOTH FILMS & REPORTS

Patient Signature: _____

Date: _____