breastlink

Breastlink Medical Information/Record Release Authorization

This is to authorize: Date of Request: _____

Name of Facility/Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

I, _____(print name), hereby authorize the release of my medical records in your procession to be forwarded to (Please select from office listing below):

- ☐ Breastlink of Encino
  5363 Balboa Blvd., Suite 100
  Encino, CA 91316
  Ph: (818) 881-7633
  Fax: (818) 906-0971

- ☐ Breastlink of Manhattan Beach
  14650 Aviation Blvd., Suite #200
  Hawthorne, CA 90250
  Ph: (310) 539-2300
  Fax: (310) 539-9185

- ☐ Breastlink at the Breast Care and Imaging Center of Orange County
  230 South Main Street, Suite # 100
  Orange, CA 92868
  Ph: (714) 541-0101
  Fax: (714) 541-0450

- ☐ Breastlink of Temecula Valley
  25455 Medical Center Dr., Ste 200
  Murrieta, CA 92562
  Ph: (951) 894-7056
  Fax: (951) 894-2702

- ☐ Breastlink of Pleasanton
  5924 Stoneridge Dr., Suite #108
  Pleasanton, CA 94588
  Ph: (925) 225-0138
  Fax: (925) 225-0850

- ☐ Breastlink Research Group
  2600 Redondo Ave., Suite 405
  Long Beach, CA 90806
  Ph: (562) 981-6101
  Fax: (562) 981-6109

- ☐ Breastlink of Rancho Mirage
  35-800 Bob Hope Dr., Suite #225
  Rancho Mirage, CA 92770
  Ph: (760) 324-4466
  Fax: (760) 324-1287

Please specify type of information being requested:

_____

_____

_____

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____