

**O P E N
ADVANTAGE**

M R I

We scan with compassion

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____, authorize and request release of all medical records from my referring physician _____, regarding my MRI(s):

TO:

**Open Advantage MRI
600 N. Tustin Ave Suite 100
Santa Ana, CA 92705**

**Phone: (714) 479-0400
Fax: (714) 479-0132**

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. A copy of facsimile of this authorization with my signature may be used with the same effectiveness as an original.

Name: _____ DOB: _____

Signature: _____ Date: _____

CORPORATE
Santa Ana
Toll Free 800-479-0488
Tel 714/479-0400
Fax 714/480-8724
600 N. Tustin Ave
Suite 100
Santa Ana, CA 92705

Brea
Tel 714/256-9754
Fax 714/256-9755
10 Pointe Drive
Suite 110
Brea, CA 92821

Sacramento
Tel 916/929-2178
Fax 916/929-6078
800 Howe Avenue
Suite 230
Sacramento, CA 95825

Westlake Village
Tel 805/230-2198
Fax 805/230-1307
2815 Townsgate Road
Suite 133
Westlake Village, CA 91361