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: ___________________________