Grossman Imaging Centers
Community Memorial Health System

Irwin Grossman, M.D. · Medical Director
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Authorization to Release Information

Date: _____

Patient Name: _____
MRN: _____
DOB: _____

If you have had any previous x-rays or other diagnostic imaging studies related to the medical reason for your study at Grossman Imaging Center and you did not bring the films and report with you, this form allows us to obtain those records for comparison purposes on your behalf.

I_____, hereby authorize and request you to release my:

Films: _____

Report: _____

In your possession concerning my illness to:

Grossman Imaging Center
Attn: Medical Records
2001 N. Solar Dr. Suite# 135
Oxnard, CA 93036

_____ _____
Signature of Patient (or Parent/Guardian) Date/Time

If signed by other than patient, please indicate name: _____

If signed by other than patient, please indicate relationship: _____