260 East Ontario Ave, Suite 101A
Corona, CA 92879
tel. 951.284.1920
fax. 951.284 1921
email. info@ieimagingcenter.com

Authorization for Release of Information

PATIENT NAME: ________________________________ DATE OF BIRTH: _________________

REQUEST OF MEDICAL RECORDS INDICATED BELOW:

☐PATIENT DEMOGRAPHICS & INSURANCE INFO ☐DOCTOR'S ORDER WITH DX CODES

☐ LABS (eGFR ABOVE 60 WITHIN LAST 30 DAYS) ☐LATEST PROGRESS NOTE

☐ MOST RECENT REPORT/ CD OF IMAGES MAILED :

DOS: EXAM:

NAME OF FACILITY: ____

ADDRESS: ____

REFERRING MD: ____

PHONE: _______________________ FAX: _____________________________

I UNDERSTAND THE PURPOSE OF THIS EXCHANGE OF INFORMATION IS CONTINUITY OF CARE BETWEEN PROVIDERS.

I HEREBY AUTHORIZE THE RELEASE OF MY INFORMATION AND REQUEST THAT THEY BE SENT TO:

INLAND EMPIRE IMAGING CENTER
DR. TUSHAR PATEL, MD
ATTN: BRIIANNA
260 EAST ONTARIO AVE - SUITE 101A
CORONA, CA 92879
OFFICE: 951.284.1920 FAX: 951.284.1921

PATIENT SIGNATURE: ______________________________ DATE: _________________________