



Request of Medical Information

1. Authorization: I authorize disclosure of medical information and health records as described below:

Name of Patient : _____ Date of Birth : _____

Social Security Number : _____ - _____ - _____ Telephone : (____) _____

2. Type of Information: This authorization is limited to the following type(s) of information:

- Complete Medical Record
- Labs / EKG
- X-Rays / MRI
- PT
- Billing
- Injection Reports
- Operative Reports
- Other _____

3. Purpose of Request: My information may be used for the following purposes: **Please check all that apply.**

- Continuing Medical Care
- Transfer of Care
- Second Opinion
- Insurance
- Legal
- Personal
- Other (please specify) _____
- Request of Individual

4. Time Frame of Records Requested:

From ____ / ____ / ____ To ____ / ____ / ____

5. Duration: I understand that this authorization is valid for one year from the date next to my signature, unless otherwise noted here: _____



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6. Records May Be Released To:

Name	Relationship to Patient		
Organization	Email		
Address	City	State	Zip
Phone Number #	Fax Number #		

7. Records May Be Released From:

Name	Relationship to Patient		
Organization	Email		
Address	City	State	Zip
Phone Number #	Fax Number #		

8. Revocation: I understand that I have the right to revoke this authorization at any time by providing written notice to the healthcare provider. I am aware that the revocation will not apply to information that has already been released in response to this authorization or that is disclosed as specifically required or permitted by law.

9. Explanation: I understand that my treatment is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.



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10. Additional Copy: I understand that I have a right to receive a copy of this authorization upon my request.

11. Patient Billing: I understand I will be charged \$25.00 for personal requests. This fee is currently being waived for Santa Ana and Lake Forest patients due to the closure of those clinics.

12. Signature:

Printed Name: _____

Signature: _____ Date/Time: _____

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

Witness Signature: _____ Date/Time: _____