# SOUTH COAST PEDIATRICS


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Anaheim, CA 92804
(714) 991-5141
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## MEDICAL RECORDS RELEASE
## AUTORIZACION PARA DIVULGAR INFORMACION MEDICA

RE: _____ Male ____Female____
Name of Patient

DOB: _____
Date of Birth

**I, THE UNDERSIGNED, HEREBY AUTHORIZE _____**

Address: _____City _____State ____Zip Code_____

Telephone #: (____) _____ Fax # (____) _____

**TO PROVIDE RECORDS OF MEDICAL INFORMATION OVER THE PHONE, BY FAX, EMAIL OR BY MAIL TO:**

_____

Address: _____ City _____State _____Zip Code_____

Telephone #: (___) _____ Fax # (___) _____

Email: _____

All medical Records ____, Lab work/x-rays____, Immunization records ____, Billing Records ____, Other _____

Reason for the record release: Continuing care _____, Change of Ins._____, Referral_____, Personal use (charge applies) ___

Entire chart _____ Date Ranges _____

**Expiration**. Unless otherwise, revoked, this authorization will expire on the following date, ___/____/____ or ☐ after request for specific event or condition is fulfilled.

Name: _____
Parent, Guardian (Patient if applicable or over 18yrs old)

**Relation to the patient: _____ (parent, legal guardian, self)**

**Signature:** _____ Telephone # (  ) _____ **Date:** _____

I am advised of, and understand, my right to receive a copy of this authorization upon request.

THIS FORM MUST BE COMPLETED IN FULL BEFORE INFORMATION CAN BE RELEASED.
A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL