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AUTHORIZATION TO RELEASE INFORMATION

Patient Name (Last):_____________________________(First):______________________________

DOB: ________________________________ SS#: _______________________________________

Cell # (   ) ______________________ Day Phone # (   ) ________________________

INFORMATION REQUESTED ***FROM:***

Name:____

Address:____

City: _______________________________ State: ___________ Zip Code: ___________________

Phone: (   ) __________________________   FAX: (   )__________________________

INFORMATION REQUESTED ***TO:***

Name: ____

Address: ____

City: _______________________________ State: ___________ Zip Code: ___________________

Phone: (   ) __________________________   FAX: (   )_________________________

Information I would like sent / requested:

______________ Copies of pertinent info only (H&P, OP reports, Labs, Imaging Reports)

______________ Copy of entire medical record

______________ Other (Please Specify)____

Patient Signature: ____ Date: _______________

Please send to ***FAX# 714-223-7001*** or

Mail to: 1041 E. Yorba Linda Blvd. Suite #210, Placentia, CA 92870