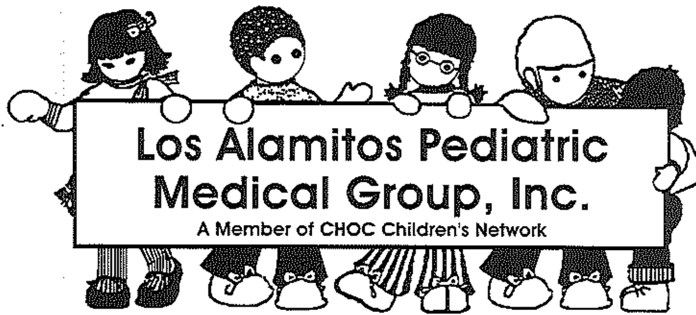

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO LOS ALAMITOS PEDIATRIC MEDICAL GROUP, A member of CHOC Children's Network

My signature below authorizes the following facility / office, to release all medical records regarding the patient listed below.

Name of Facility/Office:

____

____

____

Name of Patient records to be released:

Name: ______________________________ Date of Birth ___/___/_____

Chart Number: ______________________

Signature of Parent or Legal Guardian:

______________________________ Date: ______________________
Signature

____
Print name legibly

Signature of Witness ______________________ Date: ______________________

Date Medical Records Released: ____________________ paper copy _____ CD _____
mail _____ Fax _____ Email _____

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