CHOC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

My signature authorizes Los Alamitos Pediatric Medical Group, Inc, A Member of CHOC Children's Network, to release the medical records as indicated.

Release to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Release the following records:

ALL Medical Records: _____ Specific Information: _____

Medical Records from dates: _____to _____

Patient Name: _____ Date of Birth:_____

Patient Signature: _____ Date: _____

Patient Phone Number: _____

Office Use:

MRN #: _____ Legacy Acct #: _____

Date Mailed Date Faxed Picked Up To HIM: Associate

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