Newport Family Medicine
520 Superior Ave Suite 360
Newport Beach, CA 92663
Telephone: (949) 644-1025
Fax: (949) 644-7852

Consent To Release Medical Records

Patient Identification:

Patient Name:_____ Date of Birth:_____
Address:_____
City/State/Zip:_____
Phone #:_____

Medical Records FROM:

Name:_____
Address:_____
City/State/Zip:_____
Phone #:_____ Fax #:_____

Sending Medical Records TO:

Name:_____
Address:_____
City/State/Zip:_____
Phone #:_____ Fax #:_____

Information to be released:

□ Complete health record pertaining to any medical history, mental or physical condition and treatment received

□ Lab test results □ Pap results □ Pathology results
□ Radiology reports □ Alcohol/Drug treatment information
□ HIV test results □ Mental health treatment information
□ Immunizations

Limit records to:

Time period from:_____ to _____

This authorization **will expire one year** from the date of signature or on:_____

I understand that I may revoke this authorization at any time by sending written notice to the health care facility/provider noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.

_____
Signature of Patient or Representative Date

****If signed by representative, please state authority to act on behalf of the patient****

□ Legal Guardian/Parent □ Power of Attorney □ Other_____

****There may be a charge incurred for obtaining records****