Orange County Children's Medical Group

REQUEST TO OBTAIN HEALTH INFORMATION

By signing this, I authorize **Orange County Children's Medical Group** to obtain protected health information about:

_______________________________________ (Patient's name)

_______________________________________ (Birth Date)

_______________________________________ (Street address)

_______________________________________ (Contact Phone Number)

_______________________________________ (City, State, Zip code)

From the following discloser (health care provider):

_______________________________________ (Name)

_______________________________________ (Street address)

_______________________________________ (City, state, zip)

Information to be released:
( ) Complete medical record
( ) Summary of care
( ) Immunization records
( ) Records pertaining to:________________
____

( ) Dates of Service from _______ to _______

Send the above requested information to:

Orange County Children's Medical Group
26691 Plaza, Suite 120A
Mission Viejo, CA 92691
(949) 600-8100 office
(949) 600-8101 fax

This request will expire on:_______________________________________

I understand that:

- I have the right to refuse to sign this request. Treatment will not be conditioned on my signing this form.
- I may revoke this request in writing except to the extent that the discloser has acted in reliance upon this request. My written revocation must be submitted to the discloser as listed above.

_______________________________________ (Print name)

_______________________________________ (Relationship to Patient)

_______________________________________ (Signature)

_______________________________________ (Date)