

PLEASE EXPEDITE

APPT DATE: _____

MEDICAL RECORDS RELEASE www.ocheart.org

PATIENT INFORMATION:

Patient Name: _____

Social Security #: ____/____/____ Date of Birth: ____/____/____

PATIENT RELEASE OF INFORMATION:

I, undersigned, hereby authorize:

To release to Orange County Institute and Research Center ____ any and all medical records and specifically _____

Date(s) Year(s) of Service _____

Please forward all records to the following office location:

- o Orange Office, 1140 W La Veta Ave., #640 Orange, CA 92868
(714) 564-3300 Fax (714) 564-3318
- o Bristol Office, 2621 So. Bristol St., #204, Santa Ana, CA 92704
(714) 545-5170 Fax (714) 545-6724
- o Irvine Office, 4050 Barranca Parkway #200, Irvine, CA 92604
(949) 262-9600 Fax (949) 552-2759

USE OF INFORMATION:

The information supplied pursuant to this authorization is for diagnosis and Treatment purposes and is restricted to the use of the physician of the Orange County Heart Institute and Research Center.
No further authorization is made than is specifically indicated in this form
And an additional written consent must be obtained for any new or Different use of the information than is authorization herein, or for the Transfer of this information to another person or entity.

PATIENT:

Signature: _____ Date: _____

Witness: _____ Date: _____