

# Request for Medical Information

1. **Authorization** : I authorize disclosure of information and health records as described below:

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Telephone: \_\_\_\_\_

2. **Record Holder:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

3. **Records May Be Released To:**

Beach Family Doctors Medical Group

19582 Beach Blvd., Suite 218

Huntington Beach, CA 92648

Phone: 714-845-5900

Fax: 949-999-8113

4. **Type of Information:** This authorization is limited to the following types of information -

All Records  Discharge Summary  Progress Notes

Operative/Procedure  History/Physical Exam  Treatment for Alcohol/Drug

Abuse  Consultation Reports  HIV Test Results

Emergency Department Reports  Psychiatric Records

Laboratory Reports  Billing Information  Radiology/Nuclear Medicine

Reports  Other \_\_\_\_\_

5. **Dates of Service:** All  or From \_\_\_\_\_ To \_\_\_\_\_

6. **Use if Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please check all that apply.**

Continuing Medical Care  Second Opinion  Personal

Insurance  Legal  Other (please specify) \_\_\_\_\_

7. **Duration:** This authorization is valid for 90 days from the date next to my signature, unless otherwise noted here: \_\_\_\_\_

8. **Signature:**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If signed by other than patient, indicate your relationship to the patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_