Records Release

Date: _____

To: _____

Address: _____

Phone#: _____ Fax#: _____

I hereby authorize and request that you release my medical records to:

Dr: _____

Irvine Family Care, Inc.
4870 Barranca Parkway, Suite #350
Irvine, CA 92604

Ph# 949-417-9820 Fax# 949-417-9830

Please send the complete medical records in your possession, concerning my illness and/or treatment:

From _____ To _____

Patient Name _____
Please Print

Patient Address _____

_____

Date of Birth _____

Patient Signature _____
Parent or Guardian if minor

Witness _____

Relationship to patient _____

WE CANNOT PROCESS YOUR REQUEST WITHOUT ALL INFORMATION