IRVINE ODYSSEY MEDICAL CENTER
22 ODYSSEY, SUITE 115
IRVINE, CA 92618
949-988-7550 PHONE
949-988-7551 FAX

MEDICAL RECORDS RELEASE

PATIENT NAME _____
DATE OF BIRTH _____
PATIENT ADDRESS _____
PATIENT PHONE _____

PLEASE RELEASE ALL MEDICAL RECORDS FROM:

Doctor's Name _____
Office Address _____
Phone _____
Fax _____

SPECIFY RECORDS TO BE RELAEASE AND/OR DISCLOSED:

Check the box and initial which type of information is to be released and/or disclosed:

☐ **General Medical Information:** **From _____ to _____**

☐ **Information concerning specific injury or Treatment:**

From_____ to _____

☐ **X-Ray** (check one or both) ☐ **Films** ☐ **Reports**

☐ **Mental Health:**

From _____to_____ _____
Signature of Patient or Patient's Representative Date

☐ **Alcohol/Drugs:**

From _____to_____ _____
Signature of Patient or Patient's Representative Date

☐ **HIV Test results:**

From _____to_____ _____
Signature of Patient or Patient's Representative Date

☐ **Other (specifiy): _____**

AND SEND TO: _____
Doctor's Name
22 ODYSSEY, SUITE 115
IRVINE, CA 92618
949-988-7550 PHONE
949-988-7551 FAX

THANK YOU FOR YOUR COOPERATION AND IMMEDIATE ATTENTION TO THIS MATTER.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE