18+ Patient Information

Disclosure of Information • OC Children's Medical Group

Patient Information

Full Name:	Date of Birth:
Street Address:	
City, State, Zip:	
Cell Phone:	Email:

Authorization

I hereby authorize Orange County Children's Medical Group to release information regarding my previous and future medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including means of mail, fax, or other electronic methods to the individuals listed below:

This authorization is:

- ☐ Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)
- ☐ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Tests for Antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____ (initial)

Restrictions

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent Information

Full Name:	Relationship to patient:
Address:	
Email:	Main Subscriber on Insurance? Yes • No
Cell Phone:	Authorize disclosure? Yes • No

Full Name:	Relationship to patient:
Address:	
Email:	Main Subscriber on Insurance? Yes • No
Cell Phone:	Authorize disclosure? Yes • No

I understand that Orange County Children's Medical Group will contact me via phone call, voicemail, email, and/or mail correspondence to the contact information listed above.

Print name: _____ Signature: _____

Date: _____