Request for Transfer for Medical Records

Use and Disclosure of Information • OC Children's Medical Group

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. *Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Authorization

I hereby authorize:

Physician/Healthcare Facility:

Street Address:	
City, State, Zip code:	
Phone:	Fax:

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:

Physician/Healthcare Facility:

Street Address:	
City, State, Zip code:	
Phone:	Fax:

The medical information/records will be used for the following purpose: _____

This authorization is:

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

I

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

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consent to the specific release of the following records:

This authorization shall be effective immediately and remain in effect until:

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. I have been advised of my right to receive a copy of this authorization.

Patient's Name:	Patient's Date of Birth:
Signature of patient or legal/personal representative:	
Relationship (if other than patient):	
Witness name:	Witness Signature: