



Request for Release of Medical Records

To: Name (Doctor or Medical Facility) Address City/State/Zip Code

From: Undersigned Patient

I hereby request that my medical records, without limitation, (specifically to include any AIDS tests results and/or treatment), be released to:

Family Care Centers - Costa Mesa 1190 Baker St. Ste. 100 Costa Mesa, CA 92626 Phone: 714-668-2500 Fax: 714-668-2515

Family Care Centers - Fountain Valley 18785 Brookhurst St. Ste. 200 Fountain Valley, CA 92708 Phone: 714-378-5330 Fax: 714-378-5320

Dr. Kim Dr. Memon Dr. Nguyen Irene Miranda, PA-C

Dr. Williams Alison Omel, PA-C Danielle Godino, FNP

Dr. Coyne Dr. Foo Dr. Friehling Dr. Morey

Dr. Shoquist Dr. Tom Dr. Yan Irene Miranda, PA-C Jennifer Saiki, PA-C

Family Care Centers - Irvine 4950 Barranca Parkway Ste. 103 Irvine, CA 92604 Phone: 949-552-2700 Fax: 949-552-2701

Dr. Bunten Dr. Fishbein Alison Omel, PA-C Tamara O'Nan, PA-C

This authorization releases my medical records for the following designated purpose:

Further use or disclosure of this medical information is not authorized without an additional separate release, signed by me, unless such use is specifically required or permitted by law.

I understand that I am entitled to receive a copy of this release.

Print Patient Name Date of Birth Todays Date Patient Signature (If Minor, Parent Signature) Witness Signature