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

Dr. Kim
Dr. Memon
Dr. Nguyen

Dr. Williams
Alison Omel, PA-C
Roxanna Moridzadeh, PA-C

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

Dr. Allen
Dr. Coyne
Dr. Friehling

Dr. Shoquist
Dr. Tom
Dr. Yan
Tamara O'Nan , PA-C
Jennifer Saiki, PA-C
Wendell Witte, MD

◉ **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