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: 949-999-8121

Peter Kim, MD
Aisha Memon, MD
Gina-Nga Nguyen, MD
Jared Williams, MD
Roxanna Moridzadeh, PA-C
Alison Omel, PA-C

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

Kathryn Allen, MD
Brian Coyne, MD
Jay Friehling, MD
Katayun Saadai, MD
Jennifer Shoquist, MD
Lincoln Tom, MD
Wendell Witte, MD
Dana Yan, DO
Tamara O'Nan, PA-C
Jennifer Saiki, PA-C

☑ **Family Care Centers**
Irvine
4950 Barranca Pkwy Ste. 103
Irvine, CA 92604
Phone: 949-552-2700
Fax: 949-999-8180

David Bunten, DO
Howard Fishbein, MD
Katayun Saadai, MD
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