

Request for Medical Information

1) **Authorization** : I authorize disclosure of medical information and health records as described below:

Name of Patient: _____ **Date of Birth:** _____

Telephone: (____) _____

2) **Record Holder:** Dr. _____
(Hospital, Medical Group or other Service Provider)

Street Address

City

State

Zip

3) **Records May Be Released To:** Dr. _____

BEACH FAMILY DOCTORS MEDICAL GROUP

Dr. S. Bernbeck Dr. J. Harris

Dr. A. Mleynek

19582 Beach Blvd., Ste. 218

Huntington Beach, CA 92648

PHONE 714)845-5900 FAX 949)999-8113

4) **Type of Information:** This authorization is limited to the following type(s) of information and my initials appear beside each applicable category.

_____ All Records

_____ Progress Notes

_____ History/Physical Exam

_____ Consultation Reports

_____ Emergency Department Reports

_____ Laboratory Reports

_____ Radiology/Nuclear Medicine Reports

_____ Discharge Summary

_____ Operative/Procedure Reports

_____ Treatment for Alcohol/Drug Abuse

_____ HIV Test Results

_____ Psychiatric Records

_____ Billing Information

_____ Other _____

5) **Dates of Service:** All _____ or From _____/_____/_____ To _____/_____/_____

6) **Use of Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please Initial All That Apply.**

_____ Continuing Medical Care _____ Second Opinion _____ Personal _____ Insurance

_____ Legal _____ Other (please specify) _____

7) **Duration:** This authorization is valid for 90 days from the date next to my signature, unless otherwise noted here: _____

8) **Signature:**

Printed Name: _____

Signature: _____

Date: _____

If signed by other than patient, indicate relationship to patient: _____

Witness Signature: _____

Date: _____