

REQUEST FOR MEDICAL RECORDS

THIS DOCUMENT PROVIDES YOUR AUTHORIZATION FOR PRIOR DOCTORS AND AGENCIES TO RELEASE YOUR PREVIOUS MEDICAL RECORDS TO DR MCCANN

PATIENT INFORMATION

Name _____

Date of Birth _____

Address _____

City, State, Zip _____

Phone _____

I hereby authorize the release of the following patient medical records:

All Medical Records

Other _____

INFORMATION TO BE RELEASED

Sign next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information

Yes _____ No _____

Mental Health Information

Yes _____ No _____

AIDS/HIV Testing & Results

Yes _____ No _____

Sexually Transmitted Diseases Test/Results

Yes _____ No _____

Communicable Diseases

Yes _____ No _____

Genetic Testing

Yes _____ No _____

and is limited to the time period

from _____

to _____

TO BE RELEASED FROM

Doctor or Agency _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

TO BE RELEASED TO

Kelly K McCann, MD

1831 Orange Ave., Suite C

Costa Mesa, CA 92627

949.574.5800

949.612.2725 Fax

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will automatically expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A copy of this authorization shall be as valid as the original.

My signature below indicates I give my authorization to release my medical information as indicated.

Print Patient's Name

Patient's Signature or Signature of Legal Guardian, if applicable

Date