***Harbor Pediatric Medical Group, APC***
***601 Dover Dr., Suite 7***
***Newport Beach, CA 92663***
***(949) 645-4670***
***Fax (949) 722-6866***

# Medical Record Release Form

I authorize _____ to release medical information and health records for the following patient:

Patient Name _____ Date of Birth: _____

Please send the patient's medical records to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Please select the type of medical information you would like released:

- ☐ Entire Medical Record
- ☐ Immunization Records

- ☐ Psychiatric Records
- ☐ HIV Test Results
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ History/Physical Exam
- ☐ Laboratory Test
- ☐ Procedure Reports
- ☐ Emergency Department Reports

Dates of Service: From ____/____/____ to ____/____/____

Use of Information: The individual or entity identified above is permitted to use my information for the following purposes (please select all that apply):

- ☐ Continuing Medical Care
- ☐ Consultation
- ☐ Insurance/Billing
- ☐ Legal
- ☐ Personal

Printed Name: _____

Parent/Guardian Signature: _____

Date: _____ Relationship to patient: _____