Orange County Diagnostics
Offices: Mission Viejo, Ladera Ranch and Laguna Woods

Office Use Only

MRN _____

AUTHORIZATION
TO RELEASE PATIENT RECORDS

Patient Name: _____ DOB: __ /__ /_____

I hereby authorize:

☐ Orange County Diagnostics
27725 Santa Margarita Parkway, Suite 101
Mission Viejo, CA 92691
Phone: (949) 462-3999 Fax: (949) 462-3777

☐ Orange County Diagnostics
600 Corporate Drive, Suite 110
Ladera Ranch, CA. 92694
Phone (949) 364-5716 Fax (949) 364-5777

☐ Orange County Diagnostics
24301 Paseo De Valencia, Suite 100
Laguna Woods, CA 92637
Phone: (949) 859-0400 Fax (949) 859-0414

To disclose to: _____
Referring Doctor / Insurance Company

_____
Other Doctor

Records obtained in the course of my diagnosis and treatment at Orange County Diagnostics, specifically; Reports and/or films from diagnostic procedures.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization. I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information.

ACKNOWLEDGEMENT OF RECEIPT – PRIVACY PRACTICES

I have also been given a copy of Orange County Diagnostic's Privacy Practices. This document advises me as to how my medical information is used and how I may access that information.

This authorization expires: _____ (if blank, then 90 days after date of signature)

Signature of patient/parent/guardian: _____ Date: __ /__ /_____

Relationship to patient: _____

Witness: _____ Date: __ /__ /_____

FILM AND/OR CD REQUESTS TAKE 24 HOURS TO PROCESS