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: _____
(**Name of prior facility**)
_____
_____

To disclose to:

☐ 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

Records obtained in the course of my diagnosis and treatment at facility above, specifically;

☐ Reports from diagnostic procedures, Date(s): _____

☐ Films from diagnostic procedures, Date(s): _____

☐ Lab or other diagnostic results: _____

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.

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

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

Relationship to patient: _____

Witness: _____ Date: __ /__ /_____