Newport Pediatric Premier Care
1401 Avocado Ave Suite #705
Newport Beach, CA 92660
Office: (949) 524-8890
Fax: (949) 524-8891
NewportPediatricPC@gmail.com

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT:

Name: _____

Address: _____

Phone: _____

Birthdate: _____

RELEASE RECORDS FROM:

Office: _____

Address: _____

Phone: _____

Fax: _____

RELEASE RECORDS TO: Newport Pediatric Premier Care

Address: 1401 Avocado Ave Suite 705 Newport Beach, CA

Phone: (949) 524 - 8890 Fax: (949) 524 - 8891

PLEASE RELEASE THE FOLLOWING RECORDS:

_____ All Records

_____ Prenatal Records
_____ Progress Reports
_____ Vaccine Records
_____ Lab Reports

_____I **allow** information to be transmitted by Fax. I understand that this may limit the security or confidentiality of the records.

_____I **do not allow** information to be transmitted by Fax.

I acknowledge that I have read and fully understand this authorization.

_____ _____

(Patient Signature) (Date of Authorization)

I hereby authorize copies of my medical records to be released from Newport Pediatric Premier Care. I understand that this may include information regarding medical, surgical, psychiatric treatment, drug treatment, HIV testing, testing and/or counseling. I release Newport Pediatric Premier Care and all staff from any and all costs, liability or damages resulting directly or indirectly.