ORANGE COUNTY WOUND AND HYPERBARIC

BAROMEDICAL PHYSICIANS ASSOCIATES MEDICAL GROUP

720 No. Tustin Ave., Ste 100
Santa Ana, CA 92705
Phone: (714) 973-8777 Fax: (714) 973-8778

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name ______________________________ Birth Date: ___________________

I, the undersigned, hereby voluntarily authorize and direct ____________________________________ to provide from my medical record(s) the information specified below to:

Orange County Wound and Hyperbaric
Baromedical Physician's Associates Medical Group
720 N Tustin Ave #100
Santa Ana CA 92705
714 973 8777 fax 714 973 8778

The disclosure of records authorized if required for the following purposes:

☐ Further Medical Care ☐ Determination of Disability ☐ Insurance

☐ Attorney ☐ Other (specify): ____

I understand that this medical information may not be further used or disclosed unless another authorization is obtained from me, unless such disclosure is specifically required or permitted by law. A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original. This document valid for 12 months from date signed.

Items Requested: DOS:_______ ___ALL RECORDS ___H & P ___LAB REPORTS ___RADIOLOGY REPORTS

___MRI/CT ___ULTRASOUND/VASCULAR STUDIES

___OTHER____

Date: ____ ____

Signature (Patient, Parent, Guardian or Conservator)

____

PRINT PATIENT NAME