NewportCare®
MEDICAL GROUP
3300 WEST COAST HIGHWAY
NEWPORT BEACH, CA 92663

MEDICAL RECORDS RELEASE FORM

DATE:_____

PATIENT NAME:_____ DOB:_____

I,_____ (patient name), give NewportCare Medical Group permission to release my records to:

Name of Requestor:_____

Phone:_____ Fax:_____

Reason for request:_____

_____

(Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.)

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____

Patient's Signature **Date**