UNIVERSITY OF CALIFORNIA, IRVINE

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DEPARTMENT OF PEDIATRICS
DIVISION OF GENETICS & METABOLISM

l THE 101CITY DRIVE, ZOT 4482
ORANGE, CA 92868-3298

Authorization to Release Medical Records

Patient name: _____ Date of birth: _____

Medical record#_____ Date of Appointment: _____

I (we) authorize _____
(where records are coming from)

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

Please release medical records on the patient named above for the purposes of Research. Patient has signed a consent form.

Records requested:

___ Entire medical record

___ Other: _____

___ Other: _____

___ Other: _____

This authorization will remain effective for 12 months, and will automatically expire without express revocation by the person granting this authorization. This authorization may be cancelled with written notification, but such cancellation will have no effect on information released prior to notification of cancellation.

PERSON GRANTING THIS AUTHORIZATION:

Name: _____

Signature: _____

Relationship to patient (if not self): _____

Witness name: _____

Signature: _____

Date of authorization: _____

MAIL OR FAX RECORDS TO:

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