Orange County Migraine & Wellness Center

RECORD RELEASE

Date _____

I hereby request that my medical records be released from:

_____

Name of Provider/Clinic

_____

Street Address

_____ _____ _____

City State Zip Code

_____ _____

Phone Number Fax Number

I request that my medical records be released to:

Orange County Migraine & Wellness Center
41 Creek Road Suite 340
Irvine, CA 92604
Office Number : 949 – 861 - 8717
Fax Number : 949 – 861 – 8719

The specific records that I am requesting are :

_____

_____

_____ _____

Name of Patient Date of Birth

_____ _____

Signature of Patient Date

_____

Signature of Parent or Guardian (if patient is a minor)