Orange County Migraine & Wellness Center

EXPANDED PATIENT HEALTH ACCESS AUTHORIZATION

PATIENT:

NAME OF PATIENT [PRINT OR TYPE] | DATE OF BIRTH

SIGNATURE OF PATIENT OR GUARDIAN | DATE

AUTHORIZED INDIVIDUAL:

NAME | DATE OF BIRTH | RELATIONSHIP

PHONE NUMBER | ADDRESSS

SIGNATURE | DATE

This document serves as an authorization for *Orange County Migraine & Wellness Cente*r to release all medical information, including billing, appointment, and health information, to the individuals listed below. By signing this authorization, the patient grants permission for the designated individuals to access and discuss all relevant information regarding their healthcare.

IF PATIENT IS A MINOR / LEGALLY INCAPACIATED
Signature of Patient Representative_____
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.