



**Comprehensive Pulmonary
and Primary Care**
Physicians of Orange County

PLEASE SEND TO:
Mail: Med Rec Services
30767 Gateway Place, Suite 213
Rancho Mission Viejo, CA 92694
Phone: (800) 994-9921 or (949) 468-0505
Fax: (949) 757-1885
Email Requests To: records@medrecservices.com

**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Information:

Patient Name: _____ DOB: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone #: _____

Authorization:

I hereby authorize:

Recipient Name: _____
Address: _____ City: _____ State: _____
Zip: _____ Phone #: _____ Fax #: _____

To release my health information to:

Comprehensive Pulmonary and Primary Care of Orange County

1010 West La Veta Avenue, Suite 750
Orange, CA 92868
Phone: (714) 361-6600 | Fax: (714) 919-8804

Information Disclosure:

- All Record(s)
- Progress Note(s)
- Radiology Report(s)
- Laboratory Result(s)
- EKG
- PFT
- Immunizations
- Other (specify): _____



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Expiration:

This authorization shall become effective immediately and shall remain in effect for **ninety (90)** days from the date signed.

Restrictions:

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Signature *(as required by law):*

SIGNATURE: _____ Date: _____
(Patient/Legal Guardian or Representative)

If signed by other than the patient, print name and relationship:

Name: _____ Relationship: _____
