Irvine Doctor's of Kids & Teens
4950 Barranca Parkway, Suite 306 • Irvine, CA 92604
Phone 949-559-5601 • Fax 949-733-0680

CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR PATIENTS 18 YEARS OF AGE AND OLDER

Patient Name: First ____________________ Last ____________________
(Please Print)

Preferred Number ____

Date of Birth ____

I hereby consent to the release of medical information to:

Mother and/or Father (please list their names) ____________________

Preferred Number ____

Other ____

The medical information to include and be limited to:

_______ All Records
(Initials)

_______ Medication Records
(Initials)

_______ Progress / Doctors Notes
(Initials)

_______ Immunization Records
(Initials)

_______ Laboratory Data
(Initials)

_______ Other ____
(Initials)

(OR)

_______ DO NOT release any medical information to anyone other than myself.

My contact # is ____________________ ☐ May leave message ☐ Do not leave message

SIGNATURE ____________________ WITNESS ____________________

DATE ____________________ DATE ____________________

This consent expires one year from the date of signature