Transfer Medical Records to Ocean Pediatrics Authorization Form

Please Transfer Records To:

Ocean Pediatrics
Attention: Records

☐ **Back Bay**
2651 Irvine Ave, Suite 152
Costa Mesa, CA 92627

Phone Number: 949-781-3040
Fax Number: 949-449-8317

☐ **Laguna Hills**
24422 Avenida De La Carlota, Suite 130
Laguna Hills, CA 92653

Phone Number: 949-313-8740
Fax Number: 949-449-8215

Purpose of Transfer

X Continuation of care

Patient Information

Child's Full Name: _____

Child's Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

_____

Phone Number: _____

Email Address: _____

Current Medical Office Information

Current Medical Office Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Authorization to Release Medical Records

I, the undersigned, hereby authorize the release of the medical records of my child to Ocean Pediatrics. The records should include, but are not limited to, the following:

- Immunization records
- Growth charts
- Lab results
- X-ray and imaging reports
- Problem List
- Any other relevant medical documentation

Acknowledgment and Authorization

I understand that my child's medical records are confidential and will not be disclosed without my written consent unless required by law. I understand that I have the right to revoke this authorization at any time by providing written notice to the medical office currently holding the records. I also understand that once the records are released, they may no longer be protected under state and federal privacy laws.

_____ _____

Parent/Guardian Signature Date