Transfer Medical Records to Ocean Pediatrics Authorization Form

Please Transfer Records To:
Ocean Pediatrics
Attention: Records

☐ **NEWPORT BACK BAY**
2651 Irvine Ave, #152
Costa Mesa, CA 92627
Phone: (949) 781-3040
Fax: (949) 449-8215

☐ **LAGUNA HILLS**
24422 Avenida De La Carlota,
Suite 130
Laguna Hills, CA 92653
Phone: (949) 313-8740
Fax: (949) 449-8317

☐ **LADERA RANCH**
600 Corporate Dr, Suite 110
Ladera Ranch, CA 92694
Phone: (949) 328-1837
Fax: (949) 328-1838

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.

This form remains valid for 180 days from the date of signature.

_____ _____

Parent/Guardian Signature **Date**