Release for Medical Records

The Center For Optimal Health, Inc.
Endocrinology and Metabolism
17875 Von Karman Ave, Suite 430
Irvine, CA 92614
Phone: 949-872-2850 Fax: 949-872-2855

Patient:_____DOB:_____

I, _____, hereby consent to release my medical records from:

The Center For Optimal Health, Inc.
Jannet Huang, MD, FRCPC, FACE
Board Certified Endocrinology and Metabolism
17875 Von Karman Ave, Suite 430
Irvine, Ca 92614
Office: (949) 872-2850 Fax: (949) 872-2855

To the office of:

_____
Name of Physician / Facility / Hopital /Clinic

_____
Street Address

_____
City, State, Zip

_____ _____
Office Phone Office Fax

Please include the following:

□ All Records
□ Progress notes:_____
□ Laboratory Results / Reports:_____
□ Radiology Reports :_____
□ Other:_____

The Center for Optimal Health complies with all HIPAA requirements in medical record transfers.

Patient Signature: _____Date:_____

If person other than patient is signing, please complete the following:

_____ _____
Print First and Last Name Relationship to Patient