C. PHILIP O'CARROLL, M.D.

DIPLOMATE AMERICAN BOARD OF NEUROLOGY & PSYCHIATRY CLINICAL NEUROLOGY & ELECTROMYOGRAPHY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization for release of clinical information is being used to comply with the Confidentiality of Medical Information Act of 1081, Sec. 56 et seq., California Civil Code.

Patient's
Name:_____D.O.B.____/____/_____

INFORMATION TO BE RELEASED – *Please circle WHICH* → FROM or TO

Name:_____

Address:_____

_____

Fax Number_____

Information to be released to ☐ C. PHILIP O'CARROLL, MD (Fax:949-760-3671)

INFORMATION REQUESTED – Please check all that apply:

☐ All (Excluding Billing Records, any Psych Rep)
☐ Billing Records
☐ Tests Only (Labs, MRI, CT, etc.)
☐ Psych Reports
☐ Progress notes
☐ Other_____

This authorization is for all clinical information requested, effective immediately and expires 90 days from the date of signing. I am signing this voluntarily and I recognize that these records cannot be released without my signature. I release the above physician or facility and employees from any liability arising from the release of information as requested.

_____ _____
Signature of Patient / Representative Date

_____ _____
Relationship to Patient Witness Signature

3900 West Coast Hwy, # 330 : Newport Beach, California 92663 : (949)759-8001: Fax: (949)760-3671