

Orange County Migraine & Headache Center
Record Release Form

Date: _____

I hereby request that my medical records be released to:

To: _____

Name of provider/clinic

Street address

City/State

Zip Code

Phone number

Fax number

The medical records I am requesting are at the following address:

Orange County Migraine & Headache Center

33 Creek Road, Suite 340

Irvine, CA 92604

Office number: 949-861-8717

Fax number: 949-861-8719

The specific records that I am requesting are:

Name of Patient

Date of Birth

Signature of Patient

Date

Signature of Parent/Responsible Party (if patient minor)