Orange County Migraine & Headache Center
Record Release Form

Date:

To: _____
Name of provider/clinic

_____
Street address

_____
City/State Zip Code

_____ _____
Phone number Fax number

I hereby request that my medical records be released to:

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

_____
Date of Birth

_____
Signature of Patient

_____
Signature of Parent/Responsible Party (if patient minor)