1 25982 Pala, Suite 140, Mission Viejo CA 92691
Tel: (949) 407-4404 , **Fax:** (949) 407-4647

2 16305 Sand Canyon Ave.
Suite 220 Irvine, CA 92618

Please complete the following sections if needed:

I request my confidential medical information to be released as I have identified below:

- ☐ 1. Complete section A for medical records release by other entities to Hosseini MD Medical Inc.
- ☐ 2. Complete section B for medical records release from Hosseini MD Medical Inc.to other entities.

Patient

Patient Name: ..... Date of Birth: .....

Address: ..... Phone Number: .....

☐ All medical record	☐ Operative reports	☐ Pathology/Cytology report
☐ Discharge summary	☐ Laboratory findings	☐ Radiology reports
☐ Nuclear Medicine	☐ Other:	

Specify Reason: .....

.....

.....

.....

.....

SECTION A: I hereby authorize the following provider or organization to release the medical information of the above patient to Hosseini MD Medical Inc. 25982 Pala, Suite 140, Mission Viejo CA 92691.

NAME OF THE PHYSICIAN/ORGANIZATION: .....

Address: ..... (Street) (City) (State) (ZIP Code)

SECTION B: I hereby authorize the release of medical information on the above patient from the Hosseini MD Medical Inc. to the following provider/organization:

Name of the physician/ Organization: .....

Address: ..... Fax: .....

Note: There will be charge of $10 handling fee, 50 cents per page up to 50 pages and 25 cents per page after that.

Print Patient's Name: .....

Signature of Patient (or Legally Authorized Person): ..... Date: .....