OC GASTROCARE
Your gastro health. Our expert care.

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REQUEST TO RELEASE MEDICAL RECORDS

Date: ___/___/2016

I, _______________ PATIENT NAME __________________ (___/___/19____)

request that my medical records be released to **OCGASTROCARE (the office of Dr. Richard Dick M. Yip, Dr. Jason S. Yip, and Dr. Michael M. Kim)(fax) 714-527-2371**
from __facility or physician name and phone/fax number_ for continuity of care.

Specifically (LIST OF REQUESTED MEDICAL RECORDS, i.e. PROGRESS NOTES – dates requested, RADIOLOGY, PROCEDURE reports)

- ____
- ____
- ____
- ____
- ____
- ____

Signed ____Date___/____/2016

Print: ______________________________

Office use only:

1. Date: ____/_____/2016 initials: _________ 3. Date: ____/_____/2016 initials: _________
2. Date: ____/_____/2016 initials: _________ 4. Date: ____/_____/2016 initials: _________