BEACH PEDIATRICS
17742 Beach Blvd, Ste 360
Huntington Beach, CA 92647
Office (714) 848-0868
Fax (714) 848-2248

REQUEST FOR PROTECTED HEALTH INFORMATION

Patient Name(s): ______________________________ Date of Birth: ____________

______________________________ Date of Birth: ____________

______________________________ Date of Birth: ____________

______________________________ Date of Birth: ____________

Request For:

- ☐ Immunization Record (printed copy)
- ☐ School form
  - ☐ Preschool
  - ☐ K-12
  - ☐ Sports/Camp
  - ☐ Other
- ☐ ADHD form review and prescription — $15.00
- ☐ Medical Records, entire chart including labs, radiology, and consultations — $25.00 fee per patient

Receipt of Records:

- ☐ Call me at (_______)_______-________ to pick up.
- ☐ Send records to the following address:

____

____

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- ☐ Fax form(s) to: (_______) ________-__________
- ☐ Email to: ______________________________

SIGNATURE REQUIRED FOR RELEASE OF ALL MEDICAL RECORDS.

I, ____, authorize the release of my child/children's medical records.
Parent/Guardian Name

Parent/Legal Guardian's Signature: ________________________________ **Date:** ______________

NOTE TO PARENTS:
Please allow 3-5 business days for processing. Records received from other providers/facilities WILL NOT be released. You must obtain these records from the original provider of service.

FOR OFFICE USE:
Date Requested: _________ Date Processed: _______ ___
Total Due: __________ Payment Received on: __________
Initials: ___________

FOR OFFICE USE:
- ☐ Lindakay Rees, MD
- ☐ Patricia Stephens, MD
- ☐ Ann Ha, MD
- ☐ Rozita Pouroushasb, MD
- ☐ Other