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**REQUEST FOR MEDICAL INFORMATION/LABORATORY REPORTS FROM
GENETICS CENTER
FOR RELEASE TO ANOTHER MEDICAL ENTITY**

I am requesting that medical information be released from **GENETICS CENTER**
and be forwarded to the following:

Physician, facility, or other medical entity: _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Patient's Full Name: _____ **Date of Birth:** _____
(Last, First, M.I.)

Date of service: _____

Information Requested:

*I hereby authorize, under penalty of perjury, release of medical information/records to the
physician, facility, or other medical entity listed above:*

Patient or Legal Guardian (Print): _____

Patient or Legal Guardian's Signature: _____

Date: _____