UNICARE COMMUNITY HEALTH CENTER, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, _____,
PATIENT'S NAME

hereby authorize UCHC to release my complete medical records including the diagnosis,

treatment, X-rays and tests performed from _____
START DATE

through _____ to _____
END DATE NAME OF PHYSICIAN/MEDICAL FACILITY

located on _____
ADDRESS OF PHYSICIAN/MEDICAL FACILITY

_____ _____
TELEPHONE NUMBER FAX NUMBER

* * * * * *

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
MEDICAL RECORD # DATE OF BIRTH

_____ _____
WITNESS DATE

☐ 437 N. Euclid Ave. **Ontario, CA** 91762 –Tel (909) 988-2555 –Fax (909) 988-4447
☐ 1501 E. Holt Ave. Ste. A, **Pomona, CA** 91767 –Tel (909) 623-3600 –Fax (909) 623-3383
☐ 507 S. Mt. Vernon Ave. Ste. G, **San Bernardino, CA** 92410 –Tel (909) 884-6700 –Fax (909) 884-6705
☐ 16127 Foothill Blvd. **Fontana, CA** 92335 –Tel (909) 347-0700 –Fax (909) 355-3447
☐ 308 N. La Cadena Dr. **Colton, CA** 92324 –Tel (909) 321-4700 –Fax (909) 824-2887
☐ 2409 N. Broadway, **Los Angeles, CA** 90031 –Tel (323) 225-8038 –Fax (323) 225-2106