AstranaCare
Serving members of Anthem

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION/MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

Contact Number: _____

I hereby authorize_____release my health information/medical record to:

Astrana Care
14221 Euclid St, Garden Grove, CA 92843
Tel: (657) 206-8003 Fax: (657) 216-7083

[ ] Entire medical record [ ] Medical/Surgical History [ ] History & Physical
[ ] Physician Office Visits [ ] Medication List [ ] Test Results (lab,X-Ray.etc)
[ ] Record from Date _____to Date _____
[ ] Other: Specify _____

The purpose of this release is for:

[ ] Continuity of care or treatment
[ ] At the request of the patient/patient representative
[ ] Other (state reason):_____

_____Date:_____
Print Name of Patient or Legal Representative

_____ Date: _____
Signature of Patient or Legal Representative

_____Date:_____
Witness or Translator