

# Release for Medical Records

**The Center For Optimal Health, Inc.**  
Endocrinology and Metabolism  
3500 Barranca Parkway, Suite 305  
Irvine, CA 92606  
Phone: 949-872-2850 Fax: 949-872-2855

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, hereby consent to release my medical records from:

**The Center For Optimal Health, Inc.**  
**Jannet Huang, MD, FRCPC, FACE**  
Board Certified Endocrinology and Metabolism  
3500 Barranca Parkway, Suite 305  
Irvine, Ca 92606  
Office: (949) 872-2850 Fax: (949) 872-2855

To the office of:

\_\_\_\_\_  
Name of Physician / Facility / Hospital /Clinic

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Office Phone

\_\_\_\_\_  
Office Fax

Please include the following:

- All Records
- Progress notes: \_\_\_\_\_
- Laboratory Results / Reports: \_\_\_\_\_
- Radiology Reports : \_\_\_\_\_
- Other: \_\_\_\_\_

The Center for Optimal Health complies with all HIPAA requirements in medical record transfers.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If person other than patient is signing, please complete the following:*

\_\_\_\_\_  
Print First and Last Name

\_\_\_\_\_  
Relationship to Patient