GENETICS CENTER
211 South Main Street, Orange, California 92868
Tel 714.288.3500 & 888.4.GENETIC Fax 714.288.3510
www.geneticscenter.com

REQUEST FOR MEDICAL INFORMATION/LABORATORY REPORTS FROM

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

Physician, facility, or other:____

Address: ____

City, Zip: ____

Phone Number: ____________________________ **Fax Number**: ____________________________

Patient's Full Name: ____
(Last, First, M.I.)

Date of Birth: ______________________

Date of service: ________________________________

Information Requested: ____

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I hereby authorize release of my medical information/records to the physician or entity listed above:

Patient's Signature: ____

Date: ____________________________