Pasadena Clinical Group, APC
Verification form for Access to Medical Records
and Protected Health Information

Instructions

Complete this form entirely, once done check for errors, print it, **sign it**, attach a copy of your Driver License (or ID) and **mail it** to our office at the following address: Pasadena Clinical Group, APC - P.O. Box 5512, Pasadena, California, 91117. Do not mail this *Verification Form* unless you have already completed the online *Request Form* (ensure that the information on both forms are the same). Please allow 3-5 business days for us to receive it.

PATIENT'S INFORMATION

First name: _____ Middle Initial: ____ Last name: _____

Date of birth: _____ Age: _____ Address: _____

City: _____ State: _____ Zip code: _____ Ph#: _(_____)_____

Type of identification: ▢ Driver License ▢ Identification Card ▢ Passport ▢ Resident card

#: _____ Issuing state: _____ Exp. date: _____

REQUESTING PARTY (IF APPROPRIATE)

▢ Mother ▢ Father ▢ Foster mother ▢ Foster father ▢ Legal guardian ▢ Lawyer ▢ Family Physician

▢ Other (specify relationship to patient): _____

First name: _____ Middle Initial: ____ Last name: _____

Date of birth: _____ Age: _____ Address: _____

City: _____ State: _____ Zip code: _____ Ph#: _(_____)_____

Type of identification: ▢ Driver License ▢ Identification Card ▢ Passport ▢ Resident card

#: _____ Issuing state: _____ Exp. date: _____

Today's date: _____ Patient signature: _____

Requesting party signature: _____