West Coast Joint & Spine Center

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

PATIENT
NAME_____
LAST NAME FIRST MI

ADDRESS_____
STREET CITY STATE ZIP

PHONE ( )_____DOB:_____MEDICAL RECORD #_____

I AUTHORIZE_____TO RELEASE MEDICAL INFORMATION

FROM MY MEDICAL RECORD TO:_____

ADDRESS_____
STREET CITY STATE ZIP

I GIVE SPECIAL PERMISSION TO RELEASE INFORMATION REGARDING (INITIAL ON LINE(S) BELOW THAT YOU GRANT YOUR PERMISSION TO RELEASE INFORMATION TO ABOVE STATED ENTITY).

_____SUBSTANCE ABUSE _____PSYCHIATRIC HEALTH _____HIV INFORMATION

This authorization will automatically expire one year form the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

REASON FOR REQUEST_____

SIGNED_____DATE_____
(if not patient, state relationship to patient)

WITNESS: