SPINE & NEUROSURGERY ASSOCIATES
A Medical Corporation
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AUTHORIZATION FOR RELEASE OF INFORMATION

☐ ***Patient to pickup*** ☐ ***Fax*** ☐ ***Mail***

For Your Information:

- A charge of $20.00 will be assessed to copy your chart. Doctor to Doctor – no charge.
- Please allow 7 days for completion of all record copying requests.
- I understand that my records are protected and cannot be disclosed without my written permission.

Requested By:

Name of Patient: _____ Phone Number: _____
Address: _____ SSN: _____
City, State, Zip: _____ Date of Birth: _____

Records From:

Name of Doctor: _____ Phone Number: _____
Address: _____ Fax Number: _____
City, State, Zip: _____ Date Requested: _____

Information Requested:

☐ Lab Reports ☐ X-Ray Reports ☐ Office Visit Notes
☐ Operative Notes ☐ EKG ☐ Other: _____

Reason for Request:

☐ Send to Doctor ☐ For Own Use ☐ Other: _____

Release Records To:

Name: _____ Phone Number: _____
Address: _____ Fax Number: _____
City, State, Zip: _____ Date Requested: _____

I hereby also release the above named clinic or physician from all legal liability that may arise from the release of this information. This authorization is valid for 90 days.

_____
Signature of Patient or Legal Guardian

_____
Witness

_____
Date of Request

SPECIFIC AUTHORIZATION:

- AIDS/HIV Testing Information
- DRUG/ALCOHOL Information
- MENTAL HEALTH Information

I acknowledge that records to be released may include material that is protected by federal regulation 42 CFR, part 3 and that it is applicable to ANY of the above. My signature below authorizes the release of all information.

_____ _____
Signature Date

1301 Secret Ravine Parkway, Suite 200
Roseville, CA 95661
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