SPINE & NEUROSURGERY ASSOCIATES
A Medical Corporation
B. Barry Chehrazi, M.D., F.A.C.S.
Kavian Shahi, M.D., Ph.D.,FAANS
Hamid Aliabadi, M.D.

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: ________________________
Address: ________________________________
City, State, Zip: _________________________
Phone Number: ________________________
SSN: __________________________________
Date of Birth: ___________________________

Records From:

Name of Doctor: ________________________
Address: ________________________________
City, State, Zip: _________________________
Phone Number: ________________________
Fax Number: ___________________________
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: _________________________________
Address: ________________________________
City, State, Zip: _________________________
Phone Number: ________________________
Fax Number: ___________________________
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

Form ( )

1301 Secret Ravine Parkway, Suite 200
Roseville, CA 95661
(916) 771-3300 (916) 771-3443 Fax