

SPINE & NEUROSURGERY ASSOCIATES

A Medical Corporation

B. Barry Chehrazi, M.D., F.A.C.S.

Kavian Shahi, M.D., Ph.D.

Hamid Aliabadi, M.D.

Franklin C. Wagner, Jr., M.D., F.A.C.S., *consultant*

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