SOUTHERN CALIFORNIA
SPINE & JOINT
INSTITUTE

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(877) 657 - 8718
www.southerncaliforniaspineandjointinstitute.com

Authorization for Release of Medical Records

Patient Name: _____ **DOB:** _____

I, _____, hereby authorize Southern California Spine & Joint Institute to
(name)

☐ obtain from the following facility / person ☐ release to the following facility / person

Name: _____

Address: _____

City _____ **State** _____ **Zip** _____

Phone #: _____ **Fax #:** _____

Email: _____

Information to be obtained / released:

☐ All Records ☐ Progress Notes ☐ Operative Reports ☐ Lab Results

☐ Other _____

Exclusions: (please circle) Mental Health Opioid Dependence HIV

Date Range: _____ to _____

Reason for request: ☐ requesting for self ☐ continuation of care ☐ other: _____

I understand that I may revoke this consent at any time, and that this authorization will automatically expire 6 months from the date of signing. I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the discloser is permitted by law.

Signature: _____ Date: _____