Bay Area Pain and Spine Institute
13690 E 14th Street, Suite 230
San Leandro, CA 94578
Ph. 510 614 9200 Fx. 510 614 9203

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patients Name: _____ Date of Birth: _____

Address: _____

Contact number: _____ SSN: _____

I request and authorize the release of my medical records to:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

_____

_____

Print Name: _____

Patient Signature: _____ Date: _____

I understand that I may revoke this authorization at any time. I understand that I must revoke authorization in writing. I understand that the revocation will not apply to information already released in response to this authorization.