



DISC SURGERY CENTER AT NEWPORT BEACH
RELEASE OF MEDICAL RECORDS

____/____/____
DATE

To whom it may concern:

I _____, (____/____/____, DOB) hereby authorize the use or disclosure of my health information to the following person and / or organization:

LAST NAME:	FIRST NAME:	M.I.
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STREET		
CITY	STATE	ZIP CODE
TELEPHONE NUMBER OF PHYSICIAN/ INDIVIDUAL:		

I understand that by signing this release, confidential information may be revealed, such as alcoholism, drug abuse, HIV status and mental illness. I also understand that this release will be valid for a period of one (1) year, unless otherwise specified. I agree to solely be responsible for releasing these medical records and the information contained within.

PATIENT'S SIGNATURE

PRINT NAME

PATIENT REPRESENTATIVE

PRINT NAME

DRIVER'S LICENSE NUMBER (COPY ATTACHED) STATE