COMPREHENSIVE
SPINE & SPORTS CENTER

Campbell | Morgan Hill | Fremont
Ph: 408.356.5292
Fx: 408.356.5307
www.cssctr.com
help@cssctr.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
Please Allow 10 Business Days for Processing

Patient Information

Name: _____ Date of Birth:_____

Company Name or Representative: _____

Phone: _____ Fax: _____

Release of Information to:

I authorize the party listed above to release information contained in my medical record to the party designated below:
❑ Self ❑ Physician
❑Insurance ❑Attorney ❑Other

Name: _____ Phone: _____

Address: _____

City/State/Zip: _____

Reason for Release of Information:

_____

Information To Be Released	**Dates of Treatment**	
(Please note we can only release records that have been generated by this office)		
Complete Medical records	**❑All**	**❑ Specific dates**
Surgical	**❑All**	**❑ Specific dates**
Hospitalization	**❑All**	**❑ Specific dates**
Billing Records	**❑All**	**❑ Specific dates**

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TestResults (Please Specify:)	**❑All ❑ Specific dates**
Clinic Visit Notes	**❑All ❑ Specific dates**
Discharge Summary	**❑All ❑ Specific dates**
Other (Please Specify:)	**❑All ❑ Specific dates**

I understand that my health information may be protected by federal privacy regulations. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper.

Unless otherwise revoked, this authorization expires one year from the date of signature. A photocopy or scanned signature shall have the same force and effect as the original.

Signature of Patient or Guardian _____

Signature of Witness _____

Date Signed _____

FOR OFFICE USE
ONLY Amount Due : $_____ Amount Paid: $_____ Date Received:_____ Received By: _____