Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ Date of Birth_____

Facility Name: _____ Fax No.: _____

Facility Address: _____ Tel No: _____

The information you may release subject to this signed release form is as follows:

□Complete Records	□ History & Physical	□Progress Notes
□Care Plan	□Lab Reports	□Radiology Reports
□Pathology Reports	□Treatment Record	□Operative Reports
□Hospital Reports	□Medication Record	□Other (please specify)

Release my protected health information to the following entity: **California Sports and Spine Institute, PC (CSSI)/Maxim Moradian, MD**

Address: 1500 S. Central Ave. Suite 101 Glendale, CA 91204

Tel: (818) 338-6860 Fax: (888) 425-9079 Email: maxmoradianmd@gmail.com

Today's Date

_____

Patient Representative Name

_____

Patient's Signature:

_____

Patient Representative Signature

_____

Patient's Date of Birth

_____

Patient's Social Security Number

_____