COASTNEURO
2 James Way, Suite 101 Pismo Beach, CA

Release of Information Request

Patient Name: _____

Previous, Birth, or Maiden Name(s): _____

Date of Birth: _____ **Social Security Number:** ____ — ____ — ____

I hereby authorize and request:

- ☐ My medical records be released to the person or agency listed below.
- ☐ My X-rays, digital scans, and interpretations be released to the person or agency listed below.
- ☐ My medical records be obtained from the person or agency listed below.
- ☐ My X-rays, digital scans, and interpretations be obtained from the person or agency listed below.

(List names, addresses, and phone and fax numbers of doctors, individuals, hospitals, or agencies included in release.)

To: _____

_____

From: _____

_____

I authorize the following information to be included:

- ☐ Any and all information from my medical records, X-rays, and digital scans.
- ☐ Any and all information from my medical records, X-rays, and digital scans EXCEPT information pertaining to substance abuse (drugs and alcohol), mental health, and AIDS/HIV.
- ☐ ONLY the following information: _____

This authorization is effective for _____ months after the date it is signed. I understand that I may revoke this authorization at any time prior to that time, except to the extent that action has already been taken in reliance on it, by giving written notice to the health care provider or record keeper.

I hereby authorize the release of information as indicated above.

_____ _____

Signature of Patient or Legal Guardian Date

Relationship to patient: _____