SOUTHERN CALIFORNIA SPINE INSTITUTE

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

Ian Armstrong, M.D.
Diplomate, American Board of Neurological Surgery

EXPLANATION:

This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1980, section 56 et seq. of the California Civil Code.

AUTHORIZATION FOR EXCHANGE OF INFORMATION:

Patient Name:______________________________________ Date of Birth: ______________________

Social Security Number: ____________________________ Phone Number: ____________________

Obtain From: ____

Release to: ____

I authorize the above-referenced physician or representative to release and/or receive the following information for the purpose of evaluation, review investigation and/or treatment planning:

- Entire record
- Discharge summary
- Legal Information
- Labs, X-ray, diagnostic study results
- Office notes/service rendered
- Medical and social history
- Work status
- Exchange of information about my case/care

DURATION:

This authorization is effective immediately and shall remain in effect as long as necessary for the above-referenced physician to fulfill the obligation required by activities undertaken. The above information may be exchanged orally or in writing at any time. A copy is as valid as the original. I further understand I have a right to receive a copy of this authorization upon request.

Authorized Signature (Patient): _____________________________ Date:_______________________

Witness: ____ Expiration Date:_____________