REDDING SPINE & SPORTS MEDICINE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

Email: _____

This request and authorization applies to:

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment or payment for or coverage of services. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

This authorization will expire one year from the date of the signature above.