MARTINEZ
PAIN & SPINE

Authorization to Release Medical Records

Completion of this document authorizes the disclosure of individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information.

RECORDS RELATED TO:

_____ _____
Patient's Full Name – Please Print Patient's Date of Birth

_____ _____
Contact Phone Number Social Security Number

RECORDS TO BE RELEASED:

☐ Office Notes ☐ Radiology ☐ Laboratory ☐ Medication List
☐ Entire Chart ☐ Other

RELEASE INFORMATION TO:

Martinez Pain and Spine
7777 B Milliken Ave. Ste. 310
Rancho Cucamonga, CA 91730
Phone: (909) 944-3797
Fax: (909) 944-3914
*Records may also be sent via eClinicalworks or P2Popen.com

DURATION OF AUTHORIZATION:
This authorization will expire on the following date_____. If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____ _____ _____
Signature of patient/legal representative Date Relationship (if other than patient)