California Spine Care
Santi Rao MD
SPINAL DISORDERS & SURGERY
Tel: 925 691 1700 Fax: 925 691 1707

I authorize California Spine Care to disclose the following information from the health record of:

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ MR# _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

Dates of Service: From _____ To _____

INFORMATION REQUESTED

All Pertinent Records	Operative Report	***Home Care/Hospice Records***
Assessment(s)	Pathology Report	Nursing Assessment
Consultation	X-Ray Films	Plan of Care
Discharge Summary	X-Ray Reports	Therapy Evaluation
ER Report	Billing Record	Visit Notes
EKG Report	Photos	Itemized Billing Statements
History & Physical	Specify:	Specify:
Self	Continuing Medical Care	Attorney Request

PURPOSE INFORMATION

Other (specify reason) _____

TO BE GIVEN TO

Company, Person, Facility _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Company, Person, Facility _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

INFORMATION NOT TO BE GIVEN TO

Company, Person, Facility _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I may refuse to sign this authorization form. I understand that California Spine Care will not condition or deny treatment on my signing this authorization. This form is good for 1 years from the date sign.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. California Spine Care requires revocation of this release in writing.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release California Spine Care, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient _____ Date _____