

Northern California Spine & Rehabilitation Associates
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Mark E Hambly, MD
D. Michael Hembd, MD
Stephen I Mann, MD
Gary A Schneiderman, MD

Authorization for the release of medical records

I hereby authorize the release of my medical records from Northern California Spine and Rehabilitation Associates to the physician and or the facility listed below. I understand the costs will be computed based on a copying fee of \$15.00. An additional \$15.00 will be applied for anything over 50 pages copied.

Patient Name: _____ DOB: _____

Medical Records (Includes all dictation of office visits from the physician in our office only and any diagnostics reports).

Radiological Films: # _____

Special Instructions: _____

Release my information from: ___ Mann ___ Schneiderman ___ Hambly ___ Hembd

Release my information to: _____

Address or Phone (Required): _____

This authorization expires 30 days after the date of my signature or as otherwise specified. I also understand that I may revoke this authorization at anytime, except to the extent that Northern California Spine and Rehabilitation Associates has already taken action in reliance to it.

X _____
Signature Date

THIS SECTION REQUIRES SPECIAL AUTHORIZATION

By signing below, I authorize NCSRA Medical Corporation to disclose mental health records protected by the Lanterman-Petris-Short act, drug and alcohol abuse records, and HIV test results and or AIDS related conditions.

X _____
Signature Date

Ready to file _____ Date _____
 Fees Paid

Standard Fee: \$15.00
Over 50 pages: _____
Total: _____