Yalamanchili
Brain & Spine

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Specializing in: Intracranial Surgery – Microendoscopic Discectomy – Endoscopic Surgery – Spinal Instrumentation – Minimally Invasive Surgery - Cyberknife

Authorization For Release Of Medical Records

I, the undersigned, hereby authorize_____ to release copies of any and all medical records, including those which may pertain to AIDS, ARC, HIV-related disesases, blood alcohol content, alcohol/substance abuse, and/or psychiatric records of

_____

Date of birth _____

to _____.

This authorization shall expire, without my express revocation, _____

(days or months) from the date written below. I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken based on this authorization.

_____ _____

Signature of Patient or Guardian Date

_____

Printed name and relationship of guardian

_____

Witness