# Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

Facility Name: _____ Fax No.: _____

Facility Address: _____ Tel No: _____

**The information you may release subject to this signed release form is as follows:**

| | | |
|---|---|---|
| □ Complete Records | □ History & Physical | □ Progress Notes |
| □ Care Plan | □ Lab Reports | □ Radiology Reports |
| □ Pathology Reports | □ Treatment Record | □ Operative Reports |
| □ Hospital Reports | □ Medication Record | □ Other (please specify) |

Release my protected health information to the following entity:

**iSCORE** (Interventional Spine Care and Orthopedic Regenerative Experts)

Address: 317 S. Brand Blvd., Suite 103, Glendale, CA 91204

51 N. 5th Ave, Suite 301, Arcadia, CA 91006

Tel: (818) 338-6860 & (626) 460-1096; Fax: (888) 425-9079

Email: medicalrecords@iscoreinc.com

_____ _____

Patient Name Signature of Patient or Personal representative

_____ _____

Patient Date of Birth Printed Name or patient or Personal representative

_____ _____

Date Description of Personal Representative's Authority