ARIZONA BRAIN & SPINE CENTER

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Uncommon Patient Focus

AUTHORIZTION TO RELEASE HEALTHCARE INFORMATION

Patient's last name:	First:	Middle:	Birth date: / /
Previous name			SSN

I REQUEST AND AUTHORIZE ABSC TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

Name:		Address:		
City:	State:	ZIP code:	Phone:	Fax:

THIS REQUEST AND AUTHORIZATION APPLIES TO:

Healthcare information relating to the following treatment, condition, or dates:

ALL HEALTHCARE INFORMATION

Other:

Patient/Guardian signature _____ Date _____