EBNS AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____

Date of Birth _____

Social Security # _____

I request and authorize: _____ to release healthcare information to:

East Bay Neurosurgery and Spine,
Dr. Gordon Tang,M.D.
2999 Regent Street, Suite 715
Phone: 510-841-8700
Fax: 510-295-2651

☐ Healthcare information related to the following treatment, condition, and/or dates:

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE SIGNED

Confidentiality Notice

This facsimile transmission (and/or the documents accompanying it) may contain confidential information belonging to the sender which is protected by the physician /patient privilege. The information is intended only for the use of the individual or entity named above. If you are the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the content of this information is strictly prohibited by law. If you have received this transmission in error, please immediately notify us by telephone to arrange for return of the documents.