

Gordon Tang, MD

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____

Date of Birth _____

I request and authorize _____ to release healthcare information to:

East Bay Neurosurgery and Spine, Inc
Gordon Tang, M.D.
2999 Regent Street, Suite 715
Office 510-841-8700
Fax 510-495-1440

All healthcare information

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

Other _____

Patient Signature _____ Date _____

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE SIGNED

Confidentiality Notice

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