



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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Care Plan | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Hospital Reports | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Other (please specify) |

Release my protected health information to the following entity:

iSCORE (Interventional Spine Care and Orthopedic Regenerative Experts)

Providers: **Maxim Moradian, MD** **Revik Vartanian, DO**

Address: 1500 S. Central Ave. Suite 101 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@californiasportsandspine.com

Patient Name

Signature of Patient or Personal representative

Patient Date of Birth or SSN

Printed Name or patient or Personal representative

Date

Description of Personal Representative's Authority