CSPP COMPREHENSIVE SPINE & PAIN PHYSICIANS

Reginald Ajakwe, M.D.
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CSPPdoctors.com

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 of narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name *(Please Print)*: _____ **Date of Birth**: _____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.
Initial: _____ Date: _____

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

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

_____

_____

Release my protected health information to the following physician/person/facility/entity:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

The purpose/reason for this release of information is as follows:

_____

_____ _____

Patient Name | Signature of Patient or Personal Representative

_____ _____

Burbank Office
201 S. Buena Vista St. Suite 238
Burbank, CA 91505

Tel: (818) 325-2088
Fax: (818) 563-6201

Glendale Office
1000 N. Central Ave. Suite 210
Glendale, CA 91202

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Patient Date of Birth of Social Security Number

Printed Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

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