SHERBAN SPINE INSTITUTE
8190 S. Jog Rd. Ste. 100 Boynton Beach, FL 33472
PHONE: (844) 733-3774

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

The undersigned hereby consents to and authorizes the release of all medical reports, hospital records, and X-ray films concerning my physical condition, past and present by _____ and their employees.

The information to be disclosed shall be limited to the following:

(Please check appropriate box :)

Office Reports ( )
Other (X) Please list: **ALL MEDICALS ON FILE**

This disclosure is made for the following purpose:

(Please check appropriate box :)

Continued Care (X)
Legal ( )
Other ( ) Please specify: _____

I specifically authorize the release of this information to: **Ross Sherban D.O.** and his employees, or any person authorized by him/her to examine any of the aforesaid records. This Authorization is subject to written revocation at any time except to the extent that action has been taken in reliance thereon.

PHONE: (844) 733-3774

This Authorization is limited to the furnishing of the above records only and shall not be construed as authorizing you to communicate orally or in writing concerning my medical condition other than for the purpose of furnishing records.

Signature: _____

Date: _____