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:

□ Complete Records □ History & Physical □ Progress Notes

□ Care Plan □ Lab Reports □ Radiology Reports

□ Pathology Reports □ Treatment Record □ Operative Reports

□ Hospital Reports □ Medication Record □ 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 □ James J. Lieu, DO**

Address: 317 S. Brand Blvd., Suite 103, 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@iscoreinc.com

________________________________ ___________________________________

Patient Name Signature of Patient or Personal representative

________________________________ ___________________________________

Patient Date of Birth Printed Name or patient or Personal representative

________________________________ ___________________________________

Date Description of Personal Representative’s Authority