



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Please Print)

Patient Name: _____

Today's Date: _____

Social Security Number: _____

Date of Birth: _____

- I hereby authorize Moreno Spine & Scoliosis to release any information in my chart to any medical practitioner, doctor, hospital, or medical institution/facility to which I may be referred to assist with my care.
- Additionally, I authorize Moreno Spine & Scoliosis to obtain any medical information from any medical practitioner, doctor, hospital, or medical institution/facility to assist in my care.

Signature of Patient, Guardian, or Personal Representative

Date

Thank you for choosing Moreno Spine & Scoliosis to provide your surgical care.