ST CHARLES
SPINE
INSTITUTE

Russell W. Nelson, M.D.
558 St. Charles Drive, Suite 200
Thousand Oaks, CA 91360-3901
Mail Correspondence to:
P.O. Box 4679
Thousand Oaks, CA 91359

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To ---------- Doctor or Hospital

_____ Address

I hereby authorize and request you to release

To ---------- Doctor or Hospital

_____ Address

the complete medical records in your possession, concerning my illness and/or treatment during the period from to_____

Print Name_____ Signed_____ (Patient or Nearest Relative)

D.O.B._____ Date_____

Witness ----------