



**Yalamanchili
Brain & Spine**

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Specializing in: Intracranial Surgery • Microendoscopic Discectomy • Endoscopic Surgery • Spinal Instrumentation
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby authorize _____ to release
copies of any and all medical records, including those which may pertain to AIDS, ARC,
HIV-related diseases, blood alcohol content, alcohol/substance abuse, and/or psychiatric
records of _____

Date of Birth: _____

to _____

This authorization shall expire, without my express revocation, _____
(days or months) from the date written below. I understand that I have the right to
withdraw this authorization at any time, except to the extent that action has been taken
based on this authorization.

Signature of Patient or Guardian

Date

Printed name and relationship of guardian

Witness