REQUEST FOR MEDICAL RECORDS

I hereby authorize the use or disclosure of my individually identifiable health information from:

Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

To be faxed or mailed to:

The Spine and Brain Institute

Derek A. Duke, M.D., F.A.C.S.
James S. Forage, M.D., F.A.C.S.
John Anson, M.D., F.A.C.S.
Michael Seiff, M.D., F.A.C.S.

861 Coronado Center Drive, #200
Henderson, NV 89052
P# (702) 896-0940
Fax# (702) 896-6173

8530 W. Sunset Road, #250
Las Vegas, NV 89113
P# (702) 851-0792
Fax# (702) 896-6173

By signing below, I understand that my Personal Health Information is protected by HIPAA Policies and Procedures.

Patient's Name: _____

Social Security #: _____ D.O.B.: _____

Signature: _____ Date: _____