SPINE & ORTHOPEDIC CENTER

AUTHORIZATION FOR RECORDS RELEASE

TO: _____

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I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE RECORDS TO:

SPINE & ORTHOPEDIC CENTER
DR. RAJIV SOOD
1287 GEORGIA HWY 138 SPUR RD, STE. 8
JONESBORO, GA 30236
TELEPHONE: 770-473-0038
FAX: 770-471-4290

The complete medical records in your possession concerning my treatment. I release you from all claims resulting of said records, as I realize the are part of your permanent records.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____