AUTHORIZATION FOR RELEASE OF FILMS

I, ____authorize
(Print Name)

The Spine Institute and Dr. ________________________to:

☐ Destroy my old films

☐ Return films

- Patient will pick up films
- Mail films to patient:

____
____

FedEx Acct. No
Credit Card No. ______________Exp. Date ____

From______________________ to __________________________

Signature:_________________________ Date:_______________

Return to: The Spine Institute
Attention: Sarah Phillips/Maria Gomez
444 South San Vicente, Suite 900
Los Angeles, CA 90048