Gordon Tang, MD
East Bay Neurosurgery and Spine
A Medical Corporation

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

I request and authorize _____ to release healthcare information to:

East Bay Neurosurgery and Spine, Inc
Gordon Tang, M.D.
2999 Regent Street, Suite 715
Office 510-841-8700
Fax 510-495-1440

☐ All healthcare information

☐ Healthcare information related to the following treatment, condition, and/or dates:

☐ Other:

PATIENT SIGNATURE _____ DATE _____

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE SIGNED

Confidentiality Notice

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