SBI
THE SPINE & BRAIN
INSTITUTE

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
John A. Anson, M.D.
Efrem M. Cox, M.D.
Derek A. Duke, M.D.
James S. Forage, M.D.
Angela W. Palmer, M.D.
Michael E. Seiff, M.D.
Julia Yi, M.D.

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

9280 W. Sunset Rd., Suite 210
Las Vegas, NV 89148
Phone: (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: _____