
2575 North First Street
San Jose, CA 95131
Phone: (408) 883-2088
Fax: (408) 883-2088

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Case / MIsc #: _____

_____

I, _____, request and authorize _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

**To release my healthcare information to: Thrive 20/20 to the following address:**

**2575 N. 1ST St.**

**San Jose, CA 95131**

**Fax: 408-883-2088**

_____

This request and authorization applies to:

☐ Imaging Reports : MRI / X-Ray / Other:_____

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____