



**ROBERT E. LIEBERSON, M.D., F.A.C.S. AND ASSOCIATES**

Specializing in Neurosurgery, Spine Surgery, Pain Management, Acupuncture and EMG

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**RELEASE OF RECORDS TO NCNMG, INC.**

I hereby authorized and request \_\_\_\_\_  
\_\_\_\_\_ to release all medical records, radiographs, and laboratory reports regarding the care of \_\_\_\_\_  
(specifically including any and all records regarding medications, psychiatric history, drug use, alcohol use and AIDS or HIV infection status) to Northern California Neurosurgery Medical Group, Inc., and/or Robert Lieberman, M.D.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

Relationship: \_\_\_\_\_