Pacific Center for Neurological Disease, Inc.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information:

Name _____

DOB _____

SS# _____

I hearby authorize: _____

_____

_____

to disclose records (including psychiatric, drug and/or alcohol-related), films, and/or other information obtained during the course of treatment to:

_____

_____

_____

With this authorization, I understand that any information obtained will become part of my medical file and may be revealed to the claims examiner/adjuster responsible for my claim or to my insurance company as applicable.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such a disclosure. This consent is freely given, and I have not been threatened with discontinuance or refusal of service if I do not sign this form.

I have read the release of information. I understand and agree to the terms stated on the form.

_____ _____

Patient Signature Date

_____

Parent, Conservator, or Legal Representative for the Patient