CAROLINA NEUROLOGICAL CLINIC, L.L.P.

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Authorization To Release Information

PLEASE PRINT CLEARLY:

Patient Name _____

Address _____

Phone_____ Date of Birth_____ SS#_____

I authorize _____to release information from my medical records

to _____
(Name of Doctor, Hospital, etc.)

Address _____

City/State/ Zip Code _____

for the purpose of review/examination and further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below:

( ) Entire Record

( ) Specific information _____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Reason for request _____

Signature _____ Date _____

Witness _____ Date _____

_____
For office use only

Received (date) _____ Completed by _____Date _____ Fee Paid_____