NeuroZone, Inc.
8055 W Manchester Ave., Suite 705
Playa Del Rey, CA 90293
Telephone: 310-3640 Fax: 310-526-3438

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____ Fax # of Physician: _____

Reason for Records Release: _____

These records are to be sent to Neurozone Inc. at the Playa del Rey Office at the address listed above.

Patient's Name: _____Date of Birth: _____

Address: _____State: _____ Zip Code: _____

Social Security #: _____Phone#: _____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

____ X-Ray films (Specify type/date)
____Immunizations
____Most recent 3 years of Records
____Entire Medical Record
____ Substance and Drug Abuse, if any
____ AIDS/HIV, if any
____ Genetic testing, from date
____Psychological or psychiatric conditions, if any

Other: _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____

Patient's Name **Today's Date**

_____ _____

Patient's/Parent/Guardian/Representative **Relationship to Patient**