Name- Last, First, MI		
Street Address		
City	State	Zip Code
Home Number	Cell Number	

2. Records Released from: Neurozone, Inc.

3. Records Released to: Parents, Medical Insurance, Doctor, Pediatrician

4. Information to be released: (Check all that apply)

[ ] Complete Copy of All Records
or
[ ] Brain Map Report
[ ] Insurance and Reimbursement Information
[ ] Financial and Billing Information
[ ] Lab Progress Information

5. I authorize release of my health records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original

Client Signature: _____ Date: _____