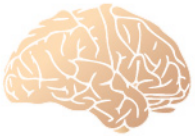

THE NEUROLOGY GROUP

ALLAN HERSKOWITZ, M.D., F.A.C.P.
BRAD HERSKOWITZ, M.D.
PAUL DAMSKI, M.D
PINZON-ARDILA, M.D.
BERNARD GRAN, M.D.
SERGIO JARAMILLO, M.D.
ALBERTO

PLEASE FAX FORM BACK TO (305) 596-0657

AUTHORIZATION / RELEASE OF MEDICAL RECORDS

I hereby request a copy of my medical records as detailed below:

□ Full medical record held by this office.
□ Medical record for the period _____ through _____
□ A specific portion/section of the record as follows:

_____

FROM (PHYSICIAN/HOSPITAL)_____

ADDRESS_____

CITY/STATE/ZIP_____

PATIENT INFORMATION

NAME_____

SOCIAL SECURITY_____-_____-_____

DATE OF BIRTH_____/_____/_____

SEND TO **The Neurology Group**
ADDRESS **9090 Sw 87 Court Suite 200**
CITY/STATE/ZIP **Miami, Fl 33176**

PHONE (305) 596-2080 **FAX (305)596-0657**

SIGNATURE_____DATE_____/_____/_____

PARENT/GARDIAN_____RELATIONSHIP_____

WITNESS_____

PLEASE RELEASE ALL MEDICAL RECORDS AND INFORMATION REGARDING MY TREATMENT, HOSPITILIZATION, AND/OR OUTPATIENT CARE FOR MY CONDITION, INCLUDING BUT NOT LIMITED TO, PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENT,DRUG ABUSE AND/OR ALCOHOLISM, SICKLE CELL ANEMIA, AIDS, AIDS-RELATED COMPLEX AND HIV ANTIBODY TESTING