AUTHORIZATION TO RELEASE MEDICAL INFORMATION/RECORD

INSTRUCTION TO THE PATIENT

This form authorizes your health care provider to release your medical records to Shankle Clinic. If you would like your records to be released to Shankle Clinic, **please fill out this form and mail or fax it to the appropriate healthcare providers**. If you would like to have more than one healthcare provider release your medical record to Shankle Clinic, please feel free to make copies of this form. We would only like records that are relative to the condition that you are seeking evaluation for. Please fill out and send only to those physician(s) that have evaluated or treated you for similar conditions.

Patient Name: _____ Date of Birth: _____

Medical record #: _____ Social Security #: _____

I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to Shankle Clinic.

Provider Name: _____

Provider Address: _____

_____

Please provide my medical record* by mail or fax to:

Shankle Clinic
3900 West Coast Hwy., Ste 310
Newport Beach, CA 92663
Phone: (949) 478-8858 / Fax: (949) 242-2465

*Please include information related to diagnostic evaluation of memory loss, dementia, or cognitive impairment such as neuropsychological testing and neuroimaging studies only.

This authorization will remain effective for one (1) year from the date this authorization is signed unless I provide a written notice of revocation to the above named provider at the provider's address. The revocation will be effective immediately upon my health care provider's receipt of such notice.

Patient Signature: _____ Date: _____

Print Patient Name: _____

Signature of Legal Representative:

_____

Print Name: _____ Date: _____

Relationship:_____