PACIFIC NEUROSCIENCE MEDICAL GROUP
1701 Solar Drive, Suite 140 □ Oxnard, CA 93030

RECORDS RELEASE AUTHORIZATION

I, _____ (*insert patient's name*), hereby request that you release my entire medical record to Pacific Neuroscience Medical Group, Inc. Please include all progress notes, medication records, lab tests and other diagnostic studies, as well as copies of all H & P's, consultation reports, discharge summaries for hospitalizations, etc.

Please list all doctors that have treated you in the past:

Doctor's name: _____ Phone: _____ Fax: _____

Doctor's name: _____ Phone: _____ Fax: _____

Doctor's name: _____ Phone: _____ Fax: _____

Doctor's name: _____ Phone: _____ Fax: _____

Doctor's name: _____ Phone: _____ Fax: _____

Doctor's name: _____ Phone: _____ Fax: _____

Patient's Signature: _____ Date: _____DOB:_____

Legal Parent or Legal Power of Attorney if patient is under the age of 18 or is unable to sign for him or herself:

_____ _____ _____
(Print Name) (Signature) (Date)

IMAGING RELEASE AUTHORIZATION

I, _____ (*insert patient's name*), hereby authorize Pacific Neuroscience Medical Group, Inc., to obtain my entire imaging record. This may include MRI, CT scan, PET CT, X-Ray's, etc., unless otherwise specified.

Please mail images on a DISC.

Please list all imaging centers that have seen you in the past:

Facility name: _____ Phone: _____ Fax: _____

Facility name: _____ Phone: _____ Fax: _____

Facility name: _____ Phone: _____ Fax: _____

Patient's Signature: _____ Date: _____DOB:_____

Legal Parent or Legal Power of Attorney if patient is under the age of 18 or is unable to sign for him or herself:

_____ _____ _____
(Print Name) (Signature) (Date)

EXPIRATION OF THESE AUTHORIZATIONS

Unless otherwise revoked, these authorizations expire on _____ *(insert applicable date/event or write "never" if you do not want this authorization to expire)*. If no date is indicated, these authorizations will expire 12 months after the date of signing this form.