

VERITYMD INC/NEUROLOGY CLINIC

AUTHORIZATION FOR THE RELEASE & DISCLOSURE OF PROTECTED HEALTH INFORMATION - OUTGOING

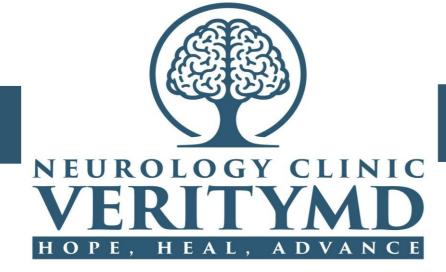
By signing this authorization, I authorize VerityMD Inc/Neurology Clinic physicians 8 associates to release and disclose protected health information about me to:		
Name of entity to receive information:		
Address (number, street	;, city, state, zip):	
Phone:	Fax:	
use and/or disclose the f me:	ts VerityMD Inc/Neurology Clinic physicians & associates to following individually identifiable health information about to be released, such as date(s) of service, types of services,	
This information is being Continuing Patient Car Insurance Personal Use Attorney/Legal Other (specify)	released for the following purpose(s): re	

I understand that my health record may include sensitive information, such as:

- Sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
- . Behavioral and/or mental health services.
- . Treatment for alcohol or drug use/abuse.

I understand that this information will be provided within 15 business days from receipt of the request, in accordance with California Health & Safety Code § 123110.





I acknowledge that a reasonable fee may be charged for preparing and furnishing copies of my medical records, as permitted under California law.

Patient Authorization
Signature of Patient or Legal Guardian
Relationship to Patient
Patient's Name
Patient's Date of Birth
Date of Signature