Kern County Neurological Medical Group, Inc.

1705 28th Street, Bakersfield, CA 93301 661.322.3008 Fax 661.322.5507

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:______________________________ Date of Birth:____________________

Address: ______________________________ Social Security #: ____________________

I authorize ***KERN COUNTY NEUROLOGICAL MEDICAL GROUP, INC.*** to release healthcare information of the patient named above **to**:

Name:

Address:

City: State: Zip Code:

I request and authorize ***KERN COUNTY NEUROLOGICAL MEDICAL GROUP, INC.*** to obtain healthcare information of the patient named above **from**:

Name:

Address:

City: State: Zip Code:

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:
- All healthcare information
- Other:

This authorization may be revoked in writing by the undersigned at anytime prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

______________________________ ____________________

Patient Signature / Personal Representative: Date Signed:

______________________________ ____________________

PRINT Patient Signature / Personal Representative: Relationship to Patient

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.