NeuroCenter

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

This authorization to receive or release medical information is being requested to you to comply with the terms of the Confidentiality of Medical Information Act of 1980, Section 56 at seq. of the California Civil Code.

Patient Name: _____ DOB: _____ SSN: _____

Patient Address: _____

City State Zip

Other Name Patient Received Treatment Under: _____

RELEASE FROM:

PHYSICIAN or FACILITY: _____

ADDRESS: _____

PHONE: _____ DATE SEEN: _____

RELEASE TO:

NEURO CENTER MEDICAL CLINIC, DR. RAJA B BOUTROS

25485 MEDICAL CENTER DRIVE SUITE 108 MURRIETA, CA 92562

PHONE: 951-696-1818 FAX: 951-696-2939

RELEASE THE FOLLOWING INFORMATION

☐ Entire Chart	☐ Operative and Pathology Reports	☐ Clinic Notes
☐ Immunization Record	☐ Extended Care Encounters	☐ Lab and X-ray Reports
☐ X-ray Films	☐ Ancillary Tests	☐ HIV Test Results
☐ History and Physical Exam	☐ Substance Abuse Records	☐ Psychiatric Records

_____ _____ _____

Patient Name (Print) Patient/Guardian Signature Date