AFFILIATED NEUROLOGY CENTER

25982 Pala, Suite 150
Mission Viejo, CA 92691

Telephone: 949-586-5500
Fax: 949-586-1600

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Social Security Number: _____

To: _____

I hereby request the following information:

_____X-ray Film/Report; _____ MRI Film/Report; _____ Medical Reports;

_____Other: _____

Please release information to:

Affiliated Neurology Center
25982 Pala, Suite 150
Mission Viejo, CA 92691

According to Section 25232 of the Health and Safety Code, these records must be provided within 15 days of receipt of this notice. A copy of this authorization will be considered valid as an original.

Signed: _____

Date: _____