NEUROCARE CENTER, INC.
4105 Holiday St. NW
PO Box 35006
Canton, OH 44735 • (330) 494-2097

☐ MAIL
☐ FAX
☐ PICK UP AT OFFICE

RECORDS NEEDED BY___/___/___

Authorization to Release NeuroCare Records

Patient: _____ ____ _____
First Name MI Last Name

_____ _____
Address City, State, Zip

Date of Birth: _____ Social Security #: _____

I hereby authorize and request NeuroCare Center, Inc. to provide to:

_____
Doctor or Hospital

Examination Mgt Svcs Inc
654 Portage Trail Ste 4
Cuyahoga Falls OH 44221
330-923-8255

_____
Address

All information in my possession for treatment during the period of _____ to _____.
Date Date

Please specify by checking the appropriate line below:

_____	All Medical Records	_____	HIV Testing &Treatment Information
_____	History and Physical	_____	Alcohol & Drug Abuse Records
_____	Progress Notes	_____	Outside Records _____
_____	Diagnostic Tests		
_____	Other (Specify): _____		

_____
(Signature Required for Outside Records)

I hereby authorize NeuroCare Center, Inc. to release a copy of my personal health information to the above named doctor, hospital, attorney, or insurance company, including records revealing the results of an HIV test, or revealing a diagnosis of AIDS or an AIDS-related condition.

I am aware that this release covers any medical and psychological testing and services that were rendered by our office.

This release will be effective for a period up to and including sixty (60) days.

Name:_____ Date:_____

Address: _____

X _____ _____
(Signature of Patient) (Signature of Parent/Legal Guardian)