I hereby authorize the Brain Performance Center to send or obtain any medical information needed for my care.

I understand that the specific information to be released may include all physician records as well as treatment of drug or alcohol abuse, mental illness, or communicable disease; this does include Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information had been made prior.

___________________________________ ______________________________

Printed Name Date

___________________________________ ______________________________________

DOB Signature

You have the right to limit medical information we disclose to someone involved in your care. If you wish to do so, please write down any persons or facilities that you do not want to receive information and the information you want limited. Please note that Brain Performance Center does not have to agree to your request.

Restrictions:

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Please List persons we may speak to regarding your care, on your behalf. (ie. Spouse, child, friend):

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