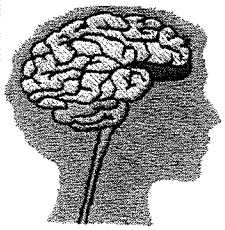

MidMichigan Neuropsychology Associates, P.L.C.

4705 Towne Centre Road
Medical Arts I, Suite 304
Saginaw, MI 48604-2821

Phone: (989) 921-5100
Fax: (989) 921-5104
Email: neuropsych@mnabrain.com

AUTHORIZATION FOR RELEASE OF MEDICAL AND PSYCHOLOGICAL INFORMATION-outgoing

PATIENT NAME: _____ **DATE OF BIRTH:** _____
PATIENT ADDRESS: _____

The undersigned hereby authorizes and requests MidMichigan Neuropsychology Associates to provide:

NAME	FAX and PHONE	DATE EXPIRED	REASON FOR EXPIRATION

or Duly Authorized Representative(s) with copies of my medical records for the purposes of review and examination and further authorizes and requests that you provide such copies thereof as may be requested, and subject to such limitations as indicated ( ) below:

( ) 1. Confined to records to include EMS report, neuro-diagnostic, radiology, H&P, consults, summary and discharge report regarding admission and treatment for the following medical condition or injury: _____ on or about (date). _____

( ) 2. Confined to the following specific information _____

( ) 3. Confined to academic records to include: grades, grade point average, class standing, any standardized test scores and any prior evaluations.

(X) 4. Without regard to any limitations placed on dates, history or illness or diagnostic and therapeutic information, including any testing and/or treatment for AIDS, AIDS-Related Complex (ARC) or HIV infection (MI 1989 Public Act 174).

Release of information is requested for purposes of Coodination of Treatment. This authorization expires one year from signature date.

SIGNATURE: _____ **DATE:** _____
RELATIONSHIP TO PATIENT: _____
WITNESS: _____ **DATE:** _____
RELATIONSHIP TO PATIENT: MIDMICHIGAN NEUROPSYCHOLOGY STAFF

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE DISCLOSURE.