C. PHILIP O'CARROLL, M.D.

DIPLOMATE AMERICAN BOARD OF NEUROLOGY & PSYCHIATRY CLINICAL NEUROLOGY & ELECTROMYOGRAPHY

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, (Patient's Name)____ with D.O.B.____/____/______, give my consent for C. PHILIP O'CARROLL, M.D., to release information regarding my medical care and to pick-up any prescriptions or records to:

Names & Relationship:

____

____

____

Doctor(s):

____

____

____

This authorization shall remain enforced unless revoked in writing and delivered to

C.PHILIP O'CARROLL, M.D.

____ ____________________

Patient's Signature Date

This authorization for release of clinical information is being used to comply with the Confidentiality of Medical Information Act of 1081, Sec. 56 et seq., California Civil Code.

3900 West Coast Hwy, # 330 : Newport Beach, California 92663 : (949)759-8001: Fax: (949)760-3671