



Authorization to Release/Obtain Patient Information

Patient Name:			Date of Birth:		
Obtain from release to (check one):			Obtain from release to (check one):		
Name			CereScan		
Phone		Fax	866-722-4806		866-433-3965
Address		991 SouthPark Dr., Ste. 200			
City	State	Zip	Littleton		CO
					80120

Please check the information to be released below.

<input type="checkbox"/> Report and Images	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Demographic Information, including Patient Billing Information	<input type="checkbox"/> Information Regarding Neurological/Psychological/Psychiatric Conditions
<input type="checkbox"/> Other	

AUTHORIZATION: I certify I have signed this request voluntarily, without any form of pressure or coercion being placed upon me by anyone. I hereby release both of the above parties from any liability which may result from this exchange of information. I understand that only I may revoke this authorization at any time, except to the extent that the action has already been taken to comply with it. **This consent will automatically expire one year after the date of signing unless otherwise indicated.**

Date Signature of Patient or Legal Guardian

Date Signature of Patient (if Patient is a Minor Child of At Least 14 Years Old or Older)