CereScan®

# Authorization to Release/Obtain Patient Information

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

**How would you like these records released?**

☐ **Email:** _____

☐ **Mail** ☐ **Fax**

**Please check the information to be released below.**

| | |
|---|---|
| ☐ Report and Images | ☐ Appointment Information |
| ☐ Demographic Information, including Patient Billing Information | ☐ Information Regarding Neurological/Psychological/Psychiatric Conditions |
| ☐ 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 I may revoke this authorization at any time, except to the extent that 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)**