PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Re: _____ Birthdate: _____
Address: _____

This will authorize _____
(Specify Doctor/Clinic)

to release information to: Chamberlain, Neaton & Johnson Address: 445 Lake, Suite 303, Wayzata, Minnesota 55391. from the medical records maintained while _____ _____was a patient at the above facility during the following period of time: _____.

The specific information to be disclosed is:

____ Emergency Room Records
____ Admission Records
____ Consultation Reports
____ Discharge Summary
____ History and Physical Exam
____ Lab Reports
____ X-Ray Reports, CT, EMG, EEG Reports
____ Doctors and Nurses Notes
____ Order Records
____ Operative Reports
____ Pathology Reports
____ Psychiatric Testing Results and Reports
____ Psychological Testing Results and Reports
____ Other _____

This authorization releases information for the purpose of litigation.

This authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization during the pendency of this proceeding.

I understand that I may revoke this consent in writing at any time. This consent will automatically expire six months following the date of signature without my express revocation. I do not authorize further release to any other third party.

A photocopy of this authorization will be treated in the same manner as an original.

Date:_____ _____
Signature: