CONSENT FOR RELEASE OF INFORMATION

We at the Illinois Neurological Institute strictly honor your privacy regarding your health information. Therefore, in order to discuss medical care and treatment with your family or friends either in the office or by telephone, we need your written consent. We will then be able to disclose evaluation and progress information, treatment plans, recommendations, etc.

Below please list those with whom we may discuss your medical care. Please list their name and relationship to you (i.e., spouse, child, parent, friend, etc.)

NAME:	RELATIONSHIP:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I hereby authorize the Illinois Neurological Institute to discuss my medical care with the above listed person(s) until I revoke this permission in writing.

____
Patient Signature (or authorized representative)

____
Date

____
Patient's Name (printed)

____
Date of Birth