Pacific
NEUROCENTER

## AUTHORIZATION TO RECEIVE/RELEASE MEDICAL INFORMATION

Client Name _____ DOB _____

Address _____

_____

*I hereby authorize the release of medical information relating to the above-named person between Neurofeedback practitioner Maryna Yudina and the following professional(s):*

_____ Phone _____

_____ Phone _____

_____ Phone _____

***For the purpose of:***

_____

(Review, Discussion, or Any Purpose Reasonably Related to the Above)

*I understand that I have the right to receive a copy of this authorization upon my request.*

Signature _____ Date _____

_____ Client _____ Parent _____ Guardian

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