WESTERN NEUROLOGICAL ASSOCIATES
A MEDICAL CORPORATION

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I have read the enclosed Notice of Patients Privacy Rights and Release of Medical Information.

Print name:_____ **Date:**_____

Signed:_____

Date of Birth: _____ **Social Security No.:**_____-_____-_____

Please check the appropriate boxes below:

- ❑ **You may call my home phone to leave me medical information.**
- ❑ **You may NOT call my home phone to leave me medical information.**
- ❑ **You may send medical information to my home.**
- ❑ **You may NOT send medical information to my home.**
- ❑ **You may give medical information to my spouse/other(Name:_____)**
- ❑ **You may NOT give medical information to my spouse.**

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