FLORIDA
NEUROLOGICAL
CENTER

Lance Kim, D.O.
Diplomate, Neurology, American Board of Neurology & Psychiatry
Diplomate, Sleep Medicine, American Board of Internal Medicine & ABPN
Diplomate, Vascular Neurology, American Board of Neurology & Psychiatry
Diplomate, Clinical Neurophysiology, American Board of Neurology & Psychiatry
Diplomate, American Board of Electrodiagnostic Medicine
Diplomate, Headache Medicine, American Board of Neurology & Psychiatry
Fellow, American Association of Sleep Medicine, International Headache Society

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

I, _____, hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company or government agency to disclose or furnish to **FLORIDA NEUROLOGICAL CENTER**, or their representatives any and all information with respect to illness including mental illness, drug/alcohol abuse, injury, medical history, dental history, consultations, prescriptions, treatments or benefits and copies of all applicable records that may be requested.

A copy of this authorization is to be considered as valid as the original.

Signed _____ Date _____

Patient Name _____ Date of Birth _____

Dr. _____ Facility _____

Fax _____--_____--_____ Fax _____--_____--_____

Please Send:

_____all records

_____records from __/__/____thru__/__/____

_____most recent laboratory studies

_____X-ray report

_____MRI report

_____EKG report

_____EEG report

TO:

_____Fax (352) 867-1040

Requested:

_____ASAP (patient is in our office now)

_____End of business day