



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.