SOUTH COAST NEUROLOGY, INC.

Disclosure Authorization Form

I, _____, hereby **PERMIT** the providers of South Coast Neurology, Inc. to disclose my health care prognosis only to the family members listed below. I understand that this authorization is voluntary.

1) _____ _____
Name Relationship

2) _____ _____
Name Relationship

3)_____ _____
Name Relationship

➡ _____ ➡ _____
Print Name Date

➡ _____ _____
Signature Witness

OR

☐ Check this box if you **DO NOT PERMIT** South Coast Neurology, Inc. to discuss your health care prognosis to any family member.

➡ _____ ➡ _____
Print Name Date

➡ _____ _____
Signature Witness

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