AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient Name/Telephone: _____

Patient Address: _____

I, the undersigned, hereby authorize "**STEPHEN M. DOLLE,**" a medical consultant, located at:

3908 ½ River Avenue
Newport Beach, CA 92663
Email: contact[at]dollecommunications.com

to review and discuss my medical records and health information, to include, hospital, nursing, physician, surgical, radiology, physical therapy, and any other medical records relating to the care and treatment of the patient, for purposes of rendering a "patient consult," and for him to make a report and discuss his findings with the person(s) and personnel designated below:

1. Include name, address, and telephone
_____
_____
_____

2. Include name, address, and telephone
_____
_____
_____

3. Include name, address, and telephone
_____
_____
_____
_____

4. Include name, address, and telephone
_____
_____
_____
_____

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization. This authorization shall remain in effect for a period of one year from the date below, or upon my written notification to terminate, whichever is sooner. I understand that this authorization is voluntary, but necessary for the consultation I seek from **STEPHEN M. DOLLE**. I understand that my medical records will be kept confidential, and that these records shall be returned to me upon termination of this authorization.

By:

_____
Print Patient Name

_____
Signature (Patient/Representative)

_____
Date

_____
Print Name Patient Representative