NEUROSCIENCE AND REHAB ASSOCIATES

NANDA N. KUMAR, M.D.
DIPLOMATE, AMERICAN BOARD OF
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AMERICAN BOARD OF CLINICAL NEUROLOGY
AMERICAN BOARD OF SLEEP MEDICINE

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I, _____ , born on,_____
(maiden name)

Do hereby authorize Dr. Nanda N. Kumar and any of his agents, to furnish medical information concerning my medical condition, including injuries, disabilities, and physical condition. This shall include all medical records and X-rays/scans in your possession covering the period:

From: _____ to: _____
(Date from) (Date to)

Inclusive Nanda N. Kumar, M.D. and any of his agents, is directed and authorized to furnish complete medical reports, past, present and future, including treatments, diagnosis, prescriptions, prognosis, and any other such information for the purpose as to be in the best interest of my medical care. Further Nanada N. Kumar, M.D., and any of his agents, is directed and authorized to permit any agent of:

_____
Name of organization to receive/view medical records/information)

_____
Address of above named organization

_____
Telephone and fax number of Above Named Organization

To view, copy, or obtain photocopies, or other such reproduction of any medical records or information in the possession of Nanda N. Kumar, M.D., covering the above stated time period. This material and information shall also include any and all information concerning the following indicated conditions/situations as I have so indicated:

___Alcohol Abuse/Alcohol
___Treatment Drug Abuse/Drug Treatment
___Psychiatric Conditions/Treatment
___AIDS/HIV Treatment

A photocopy of this document shall be considered as valid as the original.

Signature of Patient or Guardian _____

Witness _____ Date of Authorization _____