MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Medical Authorization

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____ / _____ / _____

I, _____, hereby authorize said clinic for obtaining all information relative to my physical and/or mental condition, past, present, or future from all doctors and other healthcare professionals who have treated me, and the hospitals and other healthcare institutions, in which I have ever been a patient.

Patient Signature: _____ Date: _____