AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient Name/Tel: ____

Patient Address: ____

I, the undersigned, hereby authorize "**STEPHEN M. DOLLE**" a "CNS shunt expert" located at:

3908 ½ River Avenue
Newport Beach, CA 92663
Tel. (949) 642-4592

To review my medical records and health information I provide him in the form of hospital, neurosurgery, neurology, and radiology, records relating to my hydrocephalus care and treatment, for the purposes of a "patient consult" and DiaCeph "hydrocephalus monitoring" of my hydrocephalus condition. I further authorize him to share his findings, reports, and conclusions with the physicians/other medical staff I identify below:

1. **Name**:___________________________________

   Address:_________________________________

   ____

   Tel: _____________________________________

2. **Name**:___________________________________

   Address:_________________________________

   ____

   Tel: _____________________________________

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 returned to me at the conclusion of his consultation, or termination of this authorization, whichever is sooner.

__________________________	______________________________
Print Name	Signature of Patient/Representative
______________________	______________________________
Date	Print Name of Representative