EXHIBIT 9

NeuroCare Institute of Central Florida, P.A.

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: ___________________________ Date of Birth: _______________________

Patient Address:

____
Street

____
Apartment #

____
City, State Zip

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages, plus $.25 for every page thereafter, with a minimum charge of $1.00 plus postage. These fees are in accordance with Florida law.

____________________________________ _____________________
Signature of Patient or Legal Guardia Date

____
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY: