The Center for Neuropsychology & Counseling P.C.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is for you to provide to us permission to release information to someone else. It can also be used to request others to release information to us – or both.

Who is the patient? Name _____ Date of Birth: _____

What do you want to do?
❑ I want The Center to release information to someone.
❑ I want someone to release information to The Center
❑ Both – I want The Center to exchange information with someone

Who do you want us to send/receive/exchange information with? (If there are others, use a different sheet – one per person/organization)

_____
Name of Individual or Organization

_____
Address City, State, Zip

_____
Phone Number Fax Number

Why are you requesting this? _____

What information to you want shared? (check all that apply):

[ ] Medical History and Physical	[ ] Psychological Evaluation/Reports	[ ] Treatment Summary
[ ] Discharge Summary	[ ] Medical Labs/Test Results	[ ] Allow phone calls
[ ] Imaging reports (CT, MRI, etc.)	[ ] Educational Records	[ ] Mental Health History

[ ] Other: _____

Treatment related to: (This requires specific consent. Check only the type of information you want shared)

[ ] AIDS/HIV	[ ] Psychiatric Care	[ ] Drug and alcohol treatment

I have been informed of the type of information being released; the benefits and disadvantages and I understand that services are not contingent upon my decision concerning the signing of this release. I understand that my records are protected under state and federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with state and federal law and regulations. I understand that The Center may deny this request under limited circumstances as provided for by state and federal law. This consent will expire after 12 months. However, I may revoke it at any time (in writing) except to the extent that action has already been taken. **Patients aged 14 or older who have consented to treatment need to sign this form. If a parent or guardian has consented to treatment then the parent/guardian should sign.**

_____ _____
Signature of Patient (or Parent or Guardian) Date