



CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ authorize and request
(Self, Parent, Guardian, or Authorized Representative - Please Circle)

The Center for Neuropsychology & Counseling, PC to release/obtain the following information
pertaining to the assessment and/or treatment of _____ to:

Name of Individual or Organization

Address City, State, Zip

Phone Number Fax Number

for the purpose of _____

- I do not place any restrictions on the information provided, leaving this to the discretion of staff.
- I request that the information be limited to the following:

- | | |
|--|---|
| <input type="checkbox"/> Admission Note | <input type="checkbox"/> Evaluations/Reports |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Mental Health History | <input type="checkbox"/> Educational Records |
| <input type="checkbox"/> Phone Contacts | <input type="checkbox"/> Therapeutic Services |
| <input type="checkbox"/> Other _____ | |

I have been informed of the type of information being released; the benefits and disadvantages (if any); and I understand that treatment services are not contingent upon my decision concerning the signing of this release. I understand that my records are protected as confidential 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.

However, I may revoke this consent at any time (which must be in writing) except to the extent that action has already been taken.

Executed _____ Expires _____

Patient's Name

Patient's Date of Birth

Address City, State, Zip

Signature of Patient (or Parent or Guardian)

Any individual or agency receiving this information is prohibited from making further disclosure of this information.

- Copy has been given to patient.