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Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize the psychologist (s), Associates in Neuropsychology and/or the administrative staff to release information about the psychological, cognitive, emotional, medical or social condition of

Name:_____

Date of Birth:_____

This information should only be released to (name and address of person to whom the information is to be released)

_____
_____
_____
_____
_____

I am requesting the psychologist or their administrative to release this information for the following reasons: at the request of the individual or their representative

This authorization shall remain in effect until my association with the psychologist and administrative staff is completed.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient or DPOA or Guardian Date

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.