AUTHORIZATION for RELEASE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT INFORMATION:

Patient's Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Telephone Number: _____

INFORMATION RELEASED TO AND/OR RECEIVED FROM:

Name of Person, Agency or Program:
_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

PURPOSE FOR DISCLOSURE:

	Referral for services from provider		Insurance claim
	Coordination of services between providers		Personal use
	Legal / attorney inquiry		Other: _____

I understand that the information in my mental health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), if any. It may include information about treatment for alcohol and drug abuse.

I understand that I can revoke this authorization at any time by giving written notice of revocation to Neuropsychological and Clinical Psychotherapeutic Services, LLC (NeuroPsychCPS). I understand that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I understand that this authorization is valid for six months from the date signed, unless I revoke the authorization or unless an earlier date is specified here: _____.

I understand that NeuroPsychCPS, cannot control how the authorized person or organization uses or shares the information. I understand that once the information is received by the authorized person or organization, it may be subject to disclosure and may no longer be protected by federal privacy laws.

SIGNATURE:

I have reviewed the above information and hereby authorize the above use and disclosure:

_____ Date: _____

Printed Name:
_____

Relationship to patient: [ ] Self [ ] Parent / Guardian (if child) [ ] Other _____

FOR OFFICE USE ONLY

I have reviewed this request and have authorized the release of the requested mental health records:

Clinician: _____ Date: _____