NeuroClinic and Assessments

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Consent for Release of Information

Client's Name:_____ DOB: _____

Address: _____City: _____ State:_____ Zip: _____

I, _____, authorize NeuroClinic and its employees to:

☐ send the following to ☐ receive the following from ☐ discuss protected health information with

Name: _____

Address: _____City: _____ State:_____ Zip: _____

☐ Neuropsychological testing results
☐ Psychological testing results
☐ Academic testing results
☐ Medical records
☐ Office notes
☐ *Psychotherapy notes
☐ Other, specify _____

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

This authorization shall be in force and effect for one year or until: _____ (date or event) at which time this authorization expires.

The above information will be used for planning and coordination of appropriate treatment and/or program. I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____Date:____ /____ /_____

Parent/Guardian/POA Signature: _____Date:____ /____ /_____