CLINICAL NEUROPSYCHOLOGY ASSOCIATES

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Licensed Psychologists
Diplomates in Clinical Neuropsychology ♦
Certified School Psychologists +
Certified Cognitive Rehabilitation Therapist *
Certified Biofeedback Therapist ●

RELEASE OF INFORMATION

I, _____ DOB: _____
authorize _____
to release to Clinical Neuropsychology Associates the following information:

_____

_____

I am requesting _____ to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose): _____

_____

This authorization shall remain in effect until _____ or earlier upon the receipt of written request from the patient: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the individual listed above. However, your revocation will not be effective to the extent that action has been taken in reliance on the authorization.

I understand that Clinical Neuropsychology Associates 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 this information and no longer protected by the HIPAA Privacy Rule.

_____ _____ _____
Signature of Patient/Guardian | Relationship to Patient | 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.