NEUROPSYCHOLOGICAL
REHABILITATION CENTER

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____authorize _____ and/or his or her administrative and clinical staff to release/obtain the following:

_____

This information should only be released to/obtained from: *(Name, address, contact information)*

_____

_____

_____

_____

_____

I am requesting release of this information for purposes of evaluation and/or treatment, without limitations or with the following limitations: _____

This authorization shall remain in effect until _____ or until revoked.

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my psychologist's office address. However, my revocation or modification will not be effective until my psychologist receives it. In some cases, a verbal request by phone will be sufficient to revoke the release authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of patient or legal representative Date

_____
Print Name

RECORDS STATUS: (sent/pending/revoked):_____