



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Neuropsychological Associates to
Release/receive healthcare information of the patient named above to/from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED OR UNTIL CONSENT IS REVOKED BY THE PATIENT (see below)

REVOCATION OF AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Yes No I revoke the release of any records relating to the health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____