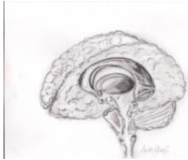
Shawanda Williams-Anderson, Ph. D.



Neuropsychological Associates
8300 Cypress Creek Parkway, Suite 450
Houston, TX 77070
Phone: (281)890-7776 Fax: (281)890-7785

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

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

Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Phone: ______________________ 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: ______________________