Associates in Neuropsychology and Behavioral Health, P.A.

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AUTHORIZATION FORM TO RELEASE PROTECTED HEALTH INFORMATION

This form authorizes Associates in Neuropsychology and Behavioral Health to release protected health information (PHI) from your clinical record to the person(s) you designate.

Patient Name ____________________________________ Date of birth _______________________

I, (your name) ____________________________________, authorize Dr. ________________________________

to release to the following individual the following patient information:

☐ Testing report

☐ Other: ____

Release to:

Name				
Affiliation (if applicable)				
Street				
City		State		Zip

Fax	

Your signature ______________________________________ Date ____________________

Your relationship to the patient:

☐ Patient ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian

☐ Other: ____