

Children's Neuropsychological Services, PLLC

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CONSENT TO OBTAIN/DISCLOSE INFORMATION

Patient Name _____ Date of Birth _____

Address _____

Phone _____

I authorize Children's Neuropsychological Services, PLLC to (Put an X next to all that apply):

- obtain medical and/or academic information from
 give information to
 both obtain information from and give information to
 send report to
 invite advocate or attorney to the feedback session, if applicable

Name _____

Address _____

Fax # _____ (if doctor's office)

for the purpose of neuropsychological evaluation of my child or myself (if adult patient). I understand that if this authorization is for the purpose of giving information, all diagnostic and therapeutic information may be included, with the following exception(s) (Put an X next to all that apply):

- no exceptions
 treatment for alcohol and drug abuse
 specific diagnostic information (specify: _____)
 specific treatment information (specify: _____)
 other (specify: _____)

This authorization may be revoked at any time except to the extent that action has already occurred in reliance thereupon. This authorization shall be valid for (90) days unless otherwise specified.

Signature of parent/guardian/adult patient _____ Date _____

Relationship to patient _____

Any redisclosure of medical record information by the recipient(s) is prohibited in connection with the further care of the patient and used solely for his or her benefit. If drug abuse or alcohol records are involved here, this information is disclosed from records from which confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibit redisclosure without specific written consent, of the persons to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information will not be sufficient for this purpose.