Neuropsychology Service, P.A. • 277 State Street, Suite 2A; Bangor, Maine 04401-5440 • Phone: (207) 990-2580 Fax: (207) 990-1930

AUTHORIZATION TO EXCHANGE INFORMATION

This form, when completed and signed, authorizes Neuropsychology Service, P.A., or an agent of the practice, to release protected information from your clinical record to the person you designate (Part B) or for the person you designate (Part A) to release information about you to Neuropsychology Service, P.A. You have a right to request and receive a copy of this completed authorization.

PATIENT NAME_____ DOB: _____ DOE: _____

PART A I authorize Neuropsychology Service, P.A., to **RECEIVE** from the following person (or his/her agent):

Name _____
Address _____
_____
_____
_____
Phone: (__) _____ Fax: (__) _____

The information to be disclosed:

□ Medical records □ Legal records □ School records
□ Diagnostic/psychological tests □ Treatment records/reports □ Employment records
□ Other _____ (description of information to be enclosed)

PART B I authorize Neuropsychology Service, P.A., to **RELEASE**:

□ Neuropsychological report
□ Other _____ (description of information to be enclosed)

This information is to be **RELEASED** to:

□ SAME AS IN PART A
□ OR TO: Name _____
Address _____
_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that any of the persons or agencies named above have already taken action on the authorization. You should be aware that your revocation may be the basis for denial of health benefits or other insurance coverage or benefits

- I understand that the Provider(s) generally may not make his/her professional services conditional on my signing an authorization unless the services are provided to me for the purpose of creating health information for a third-party.
- I understand that I may refuse authorization to disclose all or some of the healthcare information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or adverse consequences.
- I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPPA Privacy Rule.
- I understand that if I wish to review this information prior to its release, I will check this box □ Review must be supervised.

PLEASE CHECK BOXES:

□ Yes □ No I authorize the disclosure of information related to HIV/AIDS status or treatment.
□ Yes □ No I authorize the disclosure of information related to alcohol/drug abuse or treatment.
□ Yes □ No I authorize the disclosure of information related to mental health diagnosis or treatment.

This authorization shall remain in effect for one year, or until_____ (expiration date).

_____ _____
Patient Signature Date

_____ _____
[Signature of parent or legal guardian if applicable] Relationship / Basis of Authority