AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The undersigned hereby authorizes Leanne Buttross, Ph.D. and Coastal Bend Neuropsychology, PLLC to use or disclose copies of certain medical record information as specified below:

PATIENT NAME ______________________________________ MEDICAL RECORD NUMBER________________________

BIRTHDATE ______________________________ PHONE# __________________________

ADDRESS: ____

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE:

_____ NEUROPSYCH TESTING (Raw Data)*
_____ NEUROPSYCH TESTING (Summary Sheet)
_____ NEUROPSYCH TESTING (Report)
_____ PSYCH TESTING (Raw Data)*
_____ PSYCH TESTING (Report)
_____ Family member/Friend Assistance

**Raw data may only be provided to another trained/licensed psychologist for review or in special legal circumstances when raw data can be protected*

INFORMATION IS TO BE RELEASED TO:

Name ____

Address ____

____

City __________________State ______Zip __________

Phone _________________Fax ___________________

PATIENT TYPE: _____INPATIENT _____OUTPATIENT DATE(S) OF TREATMENT: ________________________________

PURPOSE OR NEED FOR THIS DISCLOSURE OF INFORMATION: _____ Continuity of Care _____ Family assistance _____ Legal proceedings _____ Other reason (below)

____

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used, or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked, the automatic expiration date will be twelve (12) months from the date of signature
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

THIS DOCUMENT SPECIFICALLY AUTHORIZES THE RELEASE OF MENTAL HEALTH OR PSYCHIATRIC INFORMATION. IF MENTAL HEALTH OR PSYCHIATRIC INFORMATION IS INCLUDED IN THE INFORMATION TO BE RELEASED TO THE PATIENT, TREATING PROVIDER OR PHYSICIAN CONSENT FOR SUCH RELEASE MUST BE OBTAINED.

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

_____________________ ____

DATE PATIENT SIGNATURE / LEGAL REPRESENTATIVE

____ ____

REASON PATIENT UNABLE TO SIGN RELATIONSHIP TO PATIENT