v.JT11.23

COMPLETE NEUROPSYCHOLOGY SERVICES
RELEASE OF INFORMATION AUTHORIZATION TO SEND RECORDS

Client's Full Name: _____ Client's Date of Birth: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following person (or entity) is authorized to use or disclose information about me:

_____ or office staff of Complete Neuropsychology Services, 500 Perry Road, Suite 202, Grand Blanc, MI 48439. Phone: (734) 386-0041 Fax: (734) 480-8870 Email: office@completenp.org

2. The following specific person/class of person/facility is authorized to request my protected health information subject to the limitations below:

Name of Individual(s)/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

3. The specific information that should be disclosed is (dates of service if possible):

_____

4. ☐ Check box to allow the exchange of verbal communication between those listed in sections 1 and 2.

5. I authorize the disclosure of my protected health information to be sent in the following format(s):

☐ USPS ☐ EMAIL
☐ PHONE ☐ FAX ☐ OTHER: _____

6. I understand that by signing this authorization my treatment, payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

7. I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

8. I may revoke this authorization by notifying the main office in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

9. My purpose/use of the information is for: _____

10. This authorization expires on: _____ **OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:**

_____

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual (the person about whom the information relates) OR, if applicable sign below	Date of Individual's Signature	Date of Birth
_____	_____	_____
Signature of Guardian or Personal Representative of the Client's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual