GOODSPEED NEUROPSYCHOLOGY

PO Box 216, East Haddam, CT 06423

860-295-3123

- Authorization for Release of information –

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including medical records, neuropsychological/psychological evaluation reports, and test data.

Patient Name:____ **Date of Birth:**______________

I authorize Goodspeed Neuropsychology, LLC, to disclose health information to: Name/Agency: Phone: Fax:		I authorize: To disclose health information to: **Goodspeed Neuropsychology** **PO Box 216** **East Haddam, CT 06423** **860-295-3123**

The purpose of this release is:

Send report______ Consultation____ Other (please specify)____________________________

I understand that I have the right to revoke or change this consent at any time, but that any revocation or changes will have no effect on previously released information. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may be no longer protected by federal privacy regulations.

This release is good for two years from the date signed.

______________________________ __________ ___________________________________

Patient Signature Date Print Name

_______________________________ __________ ___________________________________

Parent/guardian Signature Date Print Name

_______________________________ __________

Witness Date