AUTHORIZATION TO OBTAIN/RELEASE
CONFIDENTIAL RECORDS AND INFORMATION

When completed and signed by you, this form authorizes me to release/obtain protected information from your clinical record to the person you designate.

I authorize Dr. Renjan R. Mathew, Ph.D./DFW Neuropsychology, to obtain/release the following:

Please describe the information that you want to be disclosed:

☐ Results of psychological/neuropsychological evaluation
☐ Medical history and evaluation(s), and treatment information
☐ Reports of diagnostic/imaging study (MRI/CT/PET/EEG etc.)
☐ Progress notes and treatment summary
☐ Educational records
☐ Other _____

_____

This information should be obtained from/released to the following:

1. ☐ OBTAIN/ ☐ RELEASE Person/ Facility: _____

Address: _____

Phone: _____ Fax _____

2. ☐ OBTAIN/ ☐ RELEASE Person/ Facility: _____

Address: _____

Phone: _____ Fax _____

All available pertinent records or specific to the time between date _____and _____.

It has been explained to me, and I fully understand this request/authorization to release/obtain records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed or upon fulfillment of the purposes stated above.

Patient Name (Printed): _____DOB_____

Patient Signature (parent/guardian if patient is a minor): _____

Date: _____

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