BRAIN INJURY ASSOCIATION OF NEW HAMPSHIRE

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THE VOICE OF BRAIN INJURY

NEURO-RESOURCE FACILITATION

PROFESSIONAL AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize the Brain Injury Association of NH
(Individual's Name/Guardian)
to review and obtain copies of all medical, hospital or other pertinent records or information in order to assist in providing services and in developing a service plan for

_____
(Individual's Name SS# DOB)

I authorize the Brain Injury Association of NH to share information received with any institution that through a private or public funded program is a consideration for or is actually paying for all or part of my program.

I also give permission to discuss any medical, hospital or other pertinent records or information with any contact you provide to us to assist in seeking services and payments for such services.

I have had this form read and explained to me and understand its contents. I agree that a photocopy of this authorization be accepted with the same authority as the original.

I permit the use of facsimile or other electronic devices in transferring my records as needed. Sender assures all due care to protect confidentiality of records in using electronic devices.

This consent shall expire on _____

Signed _____ Date _____
Self/Guardian

Guardian's Phone Number _____

Individual's Address _____

_____

Individual's Phone Number _____

Witness _____

Relationship _____