Carolina Neuropsychological Service, Inc.

Neuropsychology & Rehabilitation Psychology
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REQUEST FOR INFORMATION

TO PROVIDE THE BEST TREATMENT FOR YOU, WE NEED TO REVIEW INFORMATION FROM YOUR OTHER HEALTH CARE PROVIDERS

I, _____, request that the following information be released to:
(PRINT FULL NAME)

Carolina Neuropsychological Service

_____ History & Physical
_____ Psychological Testing
_____ Neuropsychological Testing
_____ Discharge Summaries
_____ School Records
_____ Reports of CT/MRI/EEG
_____ Therapy Summaries
_____ Labs
_____ Work Performance Evaluations
_____ Military Records
_____ Verbal Communications
_____
_____

The purpose for the release of this data shall be for professional services only.

This authorization and request to obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part.

I understand that I may revoke this consent in writing at any time except to the extent that action based on this release has been taken. This consent will expire automatically one year from the date on which it is signed below. Earlier revocation must be received in writing.

_____ _____
Signature Patient's Date of Birth

_____ _____
Witness Today's Date

_____

- If you are a legal representative of the patient (parent or legal guardian), please indicate your authority to sign and act for the patient.

_____ _____