Coastal Neuropsychological Services

CONSENT TO RELEASE & EXCHANGE PATIENT INFORMATION

This form, when completed and signed by you, authorizes Coastal Neuropsychological Services to release protected information from your clinical record to the person you designate.

I authorize my psychologist, **Christy L. Jones, Ph.D.,** and her administrative and clinical staff, to release information to the following named requestor/person. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. The requestor should not re-disclose my medical records to another party without further written consent. I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

I Authorize the Release of my health information to:

Name: _____
(Name of person to whom the information is to be released)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

I am requesting my psychologist to release this information for the following reason: For treatment at the request of the patient or guardian.

This authorization shall remain in effect during my entire active relationship as a patient with this practice unless I rescind it specifically in writing.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have take action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Patient Name: _____
(PLEASE PRINT FULL NAME)

Patient/Parent/Legal Guardian Signature: _____ **Date:** _____
*If POA, copy of proof required