AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The undersigned hereby authorizes _____ to use or disclose copies of certain medical record information as specified below:

PATIENT NAME _____ MEDICAL RECORD NUMBER_____

BIRTHDATE _____ PHONE# _____

ADDRESS: _____

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE:

_____ History and Physical
_____ Discharge Summary
_____ Neuroimaging Report(s)
_____ Progress Notes
_____ Treatment Summary
_____ Psych Testing Results
_____ Neuropsych Testing Results
_____ Psych/Neuropsych Testing Raw Data
_____ Other _____

INFORMATION IS TO BE RELEASED TO:

Leanne M. Buttross, Ph.D.

Coastal Bend Neuropsychology, PLLC

4646 Corona Drive, Suite 258

Corpus Christi, Texas 78411

(361) 334-0256 Phone / (361) 360-3646 Records Fax

PATIENT TYPE: _____INPATIENT _____OUTPATIENT DATE(S) OF TREATMENT: _____

PURPOSE OR NEED FOR THIS DISCLOSURE OF INFORMATION: _____

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used, or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked, the automatic expiration date will be twelve (12) months from the date of signature
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

IF MENTAL HEALTH OR PSYCHIATRIC INFORMATION IS INCLUDED IN THE INFORMATION TO BE RELEASED, TREATING PROVIDER OR PHYSICIAN CONSENT FOR SUCH RELEASE MUST BE OBTAINED.

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

_____ _____

DATE PATIENT SIGNATURE / LEGAL REPRESENTATIVE

_____ _____

REASON PATIENT UNABLE TO SIGN RELATIONSHIP TO PATIENT