Neuropsychological
Solutions, PLLC
neuropsychologicalsolutions.com
P: (720) 615-8444 | **F:** (720) 844-3300

AUTHORIZATION TO EXCHANGE INFORMATION

This form, when completed and signed, authorizes Neuropsychological Solutions, PLLC, or an agent of the practice, to release protected information either in writing or via verbal communication from your clinical record to the person you designate (Part II), or for the person you designate (Part I) to release information about you to Neuropsychological Solutions. You have a right to request and receive a copy of this completed authorization.

Patient Name _____ **DOB:** _____

I. I authorize Neuropsychological Solutions, PLLC, to **RECEIVE** from the following person/agent:

Name/ Agency _____

Address: _____

_____

_____

Phone: _____ Fax: _____

The information to be disclosed:

☐ Medical Records ☐ Treatment Records ☐ School Records

☐ Other: _____

II. I authorize Neuropsychological Solutions, PLLC, to **RELEASE**:

☐ Neuropsychological Report

☐ Other_____

This information is to be RELEASED to:

☐ Same as in Part I

☐ OR to:

Name/ Agency _____

Address: _____

_____

_____

Phone: _____ Fax: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that any of the persons/agencies named above have already taken action on the authorization. By signing, you understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA Privacy Rule.

This authorization shall remain in effect for one year, or until _____ (expiration date).

_____ _____

Patient Signature Date

_____ _____

Parent/legal guardian signature if applicable Relationship