N·P·S
NealPsychologicalSpecialties, LTD

185-1 Heritage Drive
Crystal Lake, IL 60014
Nealps.com

REQUEST TO OBTAIN LETTER
(PROTECTED HEALTH INFORMATION)

This purpose of this form is to obtain a letter of diagnosis that will include protected health information. The fee for letters depends on the amount of time it takes to prepare. Fee will need to be paid prior to letter being released. If you have a balance, it will need to be paid prior to release the letter.

We require a **FIVE TO SEVEN BUSINESS DAY TURNAROUND FOR ALL REQUESTS**. If you need documents sooner, please contact our administrator at 815-477-4727.

INDIVIDUAL REQUESTING RECORDS

Name: _____ Phone No. _____ Today's Date: _____

Client Name:_____ Client DOB: _____

Date this request needs to be completed: _____

Relationship to Client: _____ NPS Clinician Name: _____

Patient Name: _____ Date of Birth: _____

*Patient's signature_____ Date_____

*Parent's signature_____ Date_____

Witness' signature_____ Date_____

*Signatures required: Adult patient (18 or older) and witness: Parent (or guardian) and child plus witness, if child is 12-17; parent (or guardian) and witness, if child is under 12 or patient adjudicated incompetent.

Specifically, what type of letter are you requesting? (If the letter is for a school, we suggest that you attach a copy of the requirements that your school needs including any forms they may require)

_____

Please release my letter to: _____

How would you like the documents sent?

- o Post Mail – Name and Address: _____
- o E-Mail – Name and E-mail Address: _____
- o Fax (Some tests cannot be faxed due to color) – Name and Fax no. _____
- o I will pick them up on _____ (please allow 5 to 7 BUSINESS DAYS TO COMPLETE and call our office to ensure we are open)

FAX THIS REQUEST TO: 815-356-8779 OR SCAN AND E-MAIL TO: sylvia.thoma@nealps.com

This information is to be used for the following purposes: **This authorization is valid for one year** from the date of signing and limited to only that information I have requested above to be sent to the facility or person named herein. The information released is not to be further disclosed or used for any purposes other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. I understand that I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility or person named herein.