N·P·S

NEALPSYCHOLOGICALSPECIALTIES, LTD

CONSENT FOR RELEASE OF INFORMATION

I, _____(date of birth)_____

address_____

authorize_____

To release the following information:

_____ permission to discuss my case

_____ copies of materials in my file: _____notes, _____test results

Please release the above information to:

_____

_____

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 anytime. 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.

*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, is child is under 12 or patient adjudicated incompetent.

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