



PERSON-CENTERED NEUROPSYCHOLOGY

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Authorization for Release and Exchange of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Connecticut and Federal law concerning the privacy of such information. I, the undersigned patient or legal representative hereby authorize Person Centered Neuropsychology, LLC to use, disclose and/or exchange private health information including, if applicable, information relating to the diagnosis of mental illness, drug and/or alcohol abuse, and confidential HIV related information regarding:

Patient's Legal Name: _____ Date of Birth: _____

Address: _____ Primary Telephone (home/cell)#: _____

I hereby authorize Person Centered Neuropsychology, LLC/Lasha Corbett, Psy.D. to: *(please check one)*

RELEASE information from my medical record TO: **OBTAIN information FROM:**

Name: _____ Address (street, city, state, zip): _____

Phone: _____ Email: _____ Fax (optional): _____

Method of Disclosure: Mail Fax Email Pick-up

- ✓ This authorization will be valid for one year from the date of signature. I understand I may cancel this authorization at any time by notifying Person Centered Neuropsychology in writing, but if I do, it will not have any effect on actions that were taken before the cancellation was received.
- ✓ **I understand that my evaluation or report generation by Person Centered Neuropsychology, LLC is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.**
- ✓ I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- ✓ I understand that I may inspect or request a copy of the information to be used or disclosed.
- ✓ I understand that Person Centered Neuropsychology and/or the party I have listed above may charge a fee for copying and postage related to the use/ disclosure of my health information under this authorization. Any such fees are the sole responsibility of the patient or his/her/their representative.

For dates of service: _____ **to** _____, **disclose the following private health information:**

History & Physical Progress Notes ED Record Discharge Summary Psych/Neuropsych. Reports

Medication List Speech Notes Labs, EEG, Radiology Reports Consultation Report

Other: _____

Purpose of requested use or disclosure: *Neuropsychological evaluation; Collaboration of care*

The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part 2. This information shall not be disclosed to anyone else without written consent or other authorization as provided on the Connecticut General Statutes and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose. ***HIV, BEHAVIORAL HEALTH, and DRUG/ALCOHOL INFORMATION contained within the medical records indicated above will be released through this authorization unless otherwise indicated here: Indicate which records you do NOT want released with your initials: _____ Behavioral Health _____ Drug/Alcohol _____ HIV-related

Print Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Signature of Patient or Authorized Representative: _____

***must provide proof of authority if authorized representative & define relationship to patient:* _____

Notice: A photocopy of this authorization shall be considered as effective and valid as the original.