

**Portsmouth Neuropsychology Center, LLC**

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Portsmouth, NH 03801

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## Authorization Form for Release/Request of Information

### CLIENT INFORMATION

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

### RELEASE OF INFORMATION

The Portsmouth Neuropsychology Center, LLC has my permission to release information contained in the record of the above named client to: \_\_\_\_\_

Information to be released: \_\_\_\_\_

Restrictions and/or exclusions (if any): \_\_\_\_\_

Purpose of Release: \_\_\_\_\_

### OBTAINING INFORMATION

The Portsmouth Neuropsychology Center, LLC has my permission to obtain information regarding the above named client from: \_\_\_\_\_

Information to be obtained: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

### SPECIFIC PROTECTIONS

Specific types of information are protected and I have the right to refuse release of this information. Initialing any of the items below indicates that I do not consent to the release of this specific information:

\_\_\_\_\_ Alcohol and/or Drug Treatment

\_\_\_\_\_ HIV-related Information

This authorization will remain in effect for one year. I understand that I may revoke this authorization, in writing, at any time. However, your revocation will not be effective to the extent that the Portsmouth Neuropsychology Center, LLC has taken action in reliance on the authorization.

I may refuse to disclose some or all of the information in my treatment record, but if I do so, it could result in improper diagnosis and/or treatment, or other adverse consequences.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

A fax or photocopy of this release will have the same validity as the original authorization.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Personal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date