Portsmouth Neuropsychology Center, LLC
501 Islington Street; Suite 1F
Portsmouth, NH 03801
Ph. (603) 433-0800
Fax (603) 297-2913

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 release:_____
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: _____ Fax:_____
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