Houston Neuropsychology Associates, PLLC

Phone: 713-893-7105 • Fax: 713-893-7145 • Email: office@houston-npa.com • Web: houston-npa.com

Authorization to Release Information

I, _____, (_____), the undersigned patient/authorizing
Patient Name **DOB**

person, do hereby authorize and request Houston Neuropsychology Associates, PLLC to mutually share information with the following person(s):

_____

List All Names Above

Information shared between Houston Neuropsychology Associates, PLLC and the person(s) listed above may include neuropsychological or psychological testing, medical history, laboratory data, diagnostic studies (e.g., MRI, CT, EEG), clinical observations, and any other information that is relevant to the patient's health care and well-being. In addition, information may be shared through any necessary mechanism of communication, including phone, postal mail, fax, e-mail, and in-person conferencing, as needed.

To the party receiving this information: This information has been disclosed to you from records, the confidentiality of which is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

In signing this authorization, it is my understanding that this information shall be held confidential, that I do not waive the doctor-patient privilege, and that the information will be utilized for professional use only. I do not authorize the person/company to whom these records are being forwarded to release them to any other person, company, or entity whatsoever. I, the undersigned, understand that I may revoke this consent at any time except the extent that action has been taken in reliance on it and that it in any event this consent shall expire one year after the date signed unless another date is specified.

_____ _____
Signature of Patient/Authorizing Person Date Signed

_____ _____
Printed Name of Patient/Authorizing Person Clinician or Witness

_____
Relationship of Authorizing Person (if applicable)