BOSTON NEUROPSYCHOLOGICAL SERVICES, LLC.

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Consent to Release and/or Obtain Confidential Information

****Please Print****

Patient Information			
Patient full name:		Date of Birth:	
Patient Address:		Phone:	
City:	State:	Zip:	Work Phone:

Check all that apply: ☐ Release information to: ☐ Obtain information from:

Name/Facility:		Attention:	
Address:		Phone:	
City:	State:	Zip:	
Fax #:	Email Address:		

Information to Release/Send

☐ History & Physical ☐ Discharge Summary ☐ ED Records ☐ Psychiatric Intake & Eval ☐ Consultation
☐ Head CT/Radiology ☐ Psych/Neuro Eval. ☐ Psychological Assess.
☐ Other:

Purpose of Disclosure

☐ Evaluation ☐ Legal ☐ Therapy ☐ Other:

I, the undersigned patient or legal representative, hereby authorized the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse, and HIV-related information.

- I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- I understand that I have a right to revoke this authorization; I must do so in writing and present my written revocation to Boston Neuropsychological Services, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy
- Unless otherwise revoked, **this authorization is given for the following dates:** to .

If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date of signing.

Signature: _____ Date:
Relationship, if other than patient:

Please note: There may be a charge for the copying and mailing of medical records.