Authorization for Release of Information

I, the undersigned patient, or legal representatives, hereby authorize the use and disclosure of health information including medical records, neuropsychological/psychological evaluation reports.

Patient Name: ____ **Date of Birth:** __________________________

<table>
<tr>
<td>

<u>Fill out for Northeast Neuropsychology to Disclose</u>
I authorize Northeast Neuropsychology to disclose health information to:
Name: _____________________________________
Address: ___________________________________
____
Telephone #: ________________________________
Fax #: _____________________________________
Email address: ______________________________

</td>
<td>

<u>Fill out for Northeast Neuropsychology to Obtain</u>
I authorize __________________________________
____
To disclose health information to:
Northeast Neuropsychology
609 West Johnson Avenue, Suite 104
Cheshire, CT 06410
Phone: 203-272-6007
Fax: 203-272-8895

</td>
</tr>
</table>

The purpose of this release is:

Send Report: _____ Consultation: _____ Other (please specify): _______________________________________

____

I understand that I have the right to revoke or change this consent at any time, but that any revocation or changes will have no effect on previously released information. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may be no longer protected by federal, privacy regulations.

This release is good for two years from the date signed.

________________________________	__________	____________________________
Patient Signature	Date	Print Name
________________________________	__________	____________________________
Parent/Guardian Signature	Date	Print Name
________________________________	__________	____________________________
Witness	Date	Print Name