Dr. Michelle A. Emick

Authorization to Release/Exchange Information

Patient's full name:____
Date of birth:_________________ Patient's address:____
City:____State___________Zip code:________________
Patient's telephone number:____________________Alternate number:____________________________
Name of parent or legal guardian, if applicable:____
Relationship to patient: ____
Address:____
City:____State___________Zip code:________________
Telephone number:________________________________ Alternate number:______________________

This form, when completed and signed by you, authorizes me to release/exchange protected information from your clinical record to/with the person/entity you designate. I authorize Dr. Michelle A. Emick and/or her administrative and clinical staff to exchange/release the following information:

Neuropsychological test report □ Treatment summary □ Other □ _________________________

This information should only be released/exchanged to/with (name and address of person to whom the information is to be released). ____
____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure). _______________________________________

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Emick generally may not condition services upon my signing an authorization unless the 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.

__________________________ __________________________________
Printed Name of Patient Signature of Patient

_________________________________ _________________________________
Printed Name of Legal Guardian, if Applicable Signature of Legal Guardian, if Applicable

_________________________________ _________________________________
Relationship of Legal Guardian to Patient Date Document Signed

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