Neuropsychology Associates, P.A.
1220 Main Avenue Suite 100 ♦ Fargo, ND 58103
Phone: (701) 297-7588 ♦ Fax: (701) 364-2256

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ Phone Number (_____) _____ - _____

Date of Birth _____/_____/_____ Chart # _____

I do hereby authorize: **To release to:** ☐ **To exchange with:** ☐

Name/Facility	Name/Facility
Address	Address
City/State/Zip	City/State/Zip
Phone / Fax	Phone / Fax

Information to be Released or Exchanged:

____ Verbal communication/exchange
____ Entire record
____ Neuropsychology consult, assessment, & progress reports
____ Psychology intake & progress reports
____ Psychiatry intake & progress reports
____ Doctor/provider progress notes
____ Alcohol/Drug Treatment records
____ Admit/Discharge summaries (specify: _____)
____ Correspondence to/from other providers
____ History and physical
____ Medical, lab, or imaging reports (specify below)
____ Operative reports
____ School records (IEP, testing reports)
____ Service dates from _____ to _____
____ Other (specify): _____

Purpose of this Release/Disclosure:

____ Coordination of care / Further assessment and/or treatment
____ Personal records
____ Education
____ Vocational rehabilitation
____ Legal
____ Worker's compensation
____ Disability determination
____ Other (specify) _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:

_____ Do **not** release records from alcohol or drug abuse treatment programs that are protected under federal law.

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that his authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. A photocopy or fax of this authorization will be treated in the same manner as the original. This **authorization expires in one year from the date of signature** unless an event, purpose, or alternative date of expiration is specified here: _____.

_____ _____ _____
Signature of Patient/Guardian/Representative Date If not patient, state authority/relationship

For office use only: