SOUTHWEST
NEUROPSYCHOLOGY
SERVICES

1515 E Missouri Ave Ste 111 • Phoenix, AZ 85014

AUTHORIZATION FOR EXCHANGE/RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize:

Southwest Neuropsychology Services PLC
1515 East Missouri Ave, Suite 110
Phoenix, AZ 85014
(602) 274-1928

And:

_____ _____

_____ _____

_____ _____

To exchange and release clinical information regarding:

_____ _____
Patient's Name Date of Birth

I understand that this consent can be withdrawn by me at any time by written notification except for information already released under this agreement. I also understand that this information cannot be re-released to a third party without my specific consent. Release information will expire automatically nine months from the date signed.

_____ _____
Patient's Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

Tel. 602-274-1928 | Fax 602-274-7402
swnpoffice@gmail.com
www.swneuropsychology.com