Wellesley Neuropsychology and Assessment, LLC

Mail or Fax to 892 Worcester Street, Suite 210, Wellesley, MA 02482

FAX: 781-383-7874

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner.

A. Patient Name _____ Phone Number (_____) _____-_____

Patient Address _____

Date of Birth _____ / _____ / _____ Case # _____

B. PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would	
☐ **To release to: (e.g., to whom you would like the information sent)** ☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent:	☐ **To exchange with: (e.g.. hospital, clinic, or provider name)**
Name/Facility	Name/Facility
Address	Address
City/State/Zip	City/State/Zip
Phone/Fax/Email SEND BY: [] Patient Portal (if available) [] Secure Email (provide email address) Patient Email Address: _____ [] Paper Copy via Mail [] Fax (provide fax number): _____ [] To be picked up by patient	Phone/Fax/Email

C. Information to be Released or Exchanged (Please check all that apply)**:**

____ Verbal communication/exchange

____ Entire record

____ Neuropsychology consult, assessment, progress reports

____ Psychology intake & progress reports

____ Psychiatry intake & progress reports

____ Doctor/provider progress notes

____ Alcohol/Substance Abuse Treatment records

____ Admit/Discharge summaries (specify: _____)

____ Correspondence to/from other providers

____ History and physical

____ Medical lab, or imaging reports

____ Operative reports

____ School records (e.g., IEP, testing reports)

____ Other (specify: _____)

Please specify the service dates from _____ to _____

D. Purpose of this Release/Disclosure (Please check the appropriate type)**:**

____ Coordination of medical care / further assessment and/or treatment

____ Personal records

____ Education/School

____ Vocational rehabilitation

____ Legal Matter

____ Worker's compensation

____ Disability determination

____ Other (specify: _____)

* Copying fees may apply

E. 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 by Federal Confidentiality Rules 42 CFR Part 2.

I authorize the use and disclosure of my individually identifiable health information as described above.

F. I understand and agree that:

- this authorization is voluntary.

- Wellesley Neuropsychology and Assessment, LLC cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Wellesley Neuropsychology and Assessment, LLC may or may not protect this information once it has been released to the recipient

- my healthcare treatment, and payment for my healthcare treatment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this agreement.

- I may revoke this authorization in writing at any time by submitting a written request to Wellesley Neuropsychology and Assessment, LLC at the address set forth on this authorization form, except to the extent action has already been taken in reliance on it (for example, once information is released, it will not be retrieved) or if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself.

- A copy or fax of this authorization will be treated in the same manner as the original.

- This authorization automatically expires in one year of the date of signature unless an event, purpose, or alternative date of expiration is specified here: _____ .

-My questions about this authorization form have been answered

_____ _____ _____

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

_____

Print Name

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

For Internal Use

Information Released/Reviewed By: _____ Date _____

If Picked-up: Identification # _____ : [] License [] State Id [] Passport [] Other Photo ID _____