SENIOR
NEUROPSYCH
ASSOCIATES

**Authorization
for the
Release of Medical Information**

I hereby authorize the release of information from the medical record of the following:

Patient Name: ______________________________ Date of Birth: _________________________

Dates of Services (if known): _________________ Daytime Phone Number: _______________

Information Released From (Name and Address)

____

____

____

Information Released To (Name and Address)

____

____

____

Please release the following medical information:

_____ Reports/Evaluations _____ Progress Notes _____ Other

Purpose for the Need for the Disclosure:

_____ Continued Patient Care _____ Legal/Attorney _____ Personal Use

_____ Insurance Claims _____ Other

I understand that the information is for the specific use stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

____ __________________________

Signature of Patient or Legal Guardian Date

____

Witness