River Valley Neuropsychology, LLC

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Release of Protected Health Information
Authorization Form

Patient Name: _____ **DOB**: _____/_____/_____

Patient Address: _____ **Phone**: _____

_____

I authorize Sarah Bullard, Ph.D. and/or her administrative and clinical staff to:

- o ___ release information from the health record to assist with my evaluation and/or treatment to:
- o ___ receive information from the health record to assist with my evaluation and/or treatment from:

Name/Organization: _____ **Phone**:_____

Address: _____ **Fax**: _____

_____

Requested information: Office notes History/physical Discharge summary
EEG report Laboratory findings Radiology: Films/report
Other:

Approximate date(s): _____

This authorization shall remain in effect until: _____

If no expiration date is listed above, I understand that the expiration date is one-year from my signature below.

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 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.

_____ _____
Signature of Patient/Legal Representative* Date

**If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.*