

Triad Neuropsychology and Forensic Services, PLLC

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Release of Information Authorization

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Contact Phone #: _____ Contact Email: _____

I agree to allow Triad Neuropsychology and Forensic Services, PLLC to send a copy of my final report to the following provider:

Provider Name and Practice Name (e.g., Joe Smith at Smith Counseling):

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Provider Email: _____

By completing this form, I am authorizing Triad Neuropsychology and Forensic Services, PLLC to release the written results from my evaluation to the provider listed above. I acknowledge that this report includes protected health information (PHI) and that Triad Neuropsychology and Forensic Services, PLLC has no ability to protect that information once it has been released. This authorization may be revoked at any time in writing. This authorization will automatically expire one year from the date signed, unless I have provided an alternative expiration date here: _____.

Signature of patient/legal representative

Date

Name of Patient (Printed): _____

Name of Legal Representative and relationship (if applicable): _____