NeuroWest Neuropsychology
3500 LaTouche St., Suite 250 Anchorage, AK 99508
info@neurowest.com / P: (907) 615-3477 / F: (907) 615-3478

Authorization to Release Protected Health Information

Patient: _____ **Date of Birth:** _____

I hereby authorize the use or disclosure of the health care and/or other information as described below. **Revocation:** I understand that authorization may be revoked at any time by written notice to NeuroWest Neuropsychology, LLC, at the address above. I understand revocation is not effective until a notice is received and is not effective regarding disclosures made before the revocation and where authorization was obtained as a condition of insurance coverage. I understand that signing this form is not a requirement for treatment at this practice. **Re-disclosure:** I understand that information released under this authorization may be subject to re-disclosure by the recipient. It may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. If I have questions about the disclosure of my health information, I can contact NeuroWest Neuropsychology, LLC at (907) 615-3477. **Expiration:** This authorization will expire one (1) year from the signature date if nothing is entered here: _____/_____/_____.

By signing below, I authorize NeuroWest Neuropsychology, LLC to (check all that apply):

__ **Receive** my health information/records from the following persons/entities:

__ **Send** my health information/records to the following persons/entities:

Name: _____

Address: _____

Fax: _____ Phone: _____ Email: _____

Information sent by/to: NeuroWest Neuropsychology, 3500 Latouche St. Suite 250, Anchorage, AK 99508, Fax: 907-615-3478; Phone: 907-615-3477; Email: info@neurowest.com

Information Requested:

__ Neuropsychological/Psychological Evaluation
__ History & Physical Exam(s)
__ Discharge Summaries
__ Laboratory Result(s)
__ Other: _____
__ Most Recent Note/Evaluation
__ Therapy Records (OT, PT, SLP
__ Imaging, EEG, and Report(s)
__ Most Recent Note / Evaluation

Reason: __ Neuropsychological Evaluation __ Care Coordination __ Treatment/Rehabilitation

Sensitive Information: I understand information may include information regarding Psychiatric Treatment, Substance Treatment, STD(s), and/or HIV. Specific Sensitive Information needs to be checked before disclosure.

___ Behavioral Health Treatment ___ Drug/Alcohol Misuse ___ HIV/AIDS Information ___ STD Information

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ **Date:** _____

A photocopy of this document is considered to be as valid as the original.