COUNSELING RESOURCES
NEUROPSYCHOLOGICAL ASSOCIATES, LLC
4785 Hayes Road, Suite 100, Madison, WI
608-242-7160 (tel) 608-242-7153 (fax)

AUTHORIZATION FOR RELEASE OF INFORMATION

Full Name of Individual: ____

DOB: ______________________ Telephone:______________________________

Address: ____

I understand that I am under no obligation to sign this form and the person (s) and/or organization (s) described below who I am authorizing to use/and or disclose my health information may not condition treatment, payment enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I also understand that the information to be released may include psychiatric, developmental disability, alcohol and/or drug abuse, HIV test results, and AIDS or AIDS related disease diagnosis information, unless otherwise specified.

My Right To Revoke This Authorization: I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact Dr. Patricia Humphrey, c/o Counseling Resources Neuropsychological Associates, 4785 Hayes Rd., Suite 100, Madison, WI 53704. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person (s) and/or organization (s) identified above have already acted in reliance upon this authorization.

Redisclosure Of My Health Information: I understand that if the person (s) and/or organization (s) listed are not health care providers, health plans or healthcare clearing houses that are subject to the federal privacy standard, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person (s) may redisclose my health information without obtaining my authorization.

Purpose or need for release of information: **Neuropsychological Eval** **Care Coordination**

I Authorize The Following Health Information To Be Used And/Or Disclosed:

- Psychological/Neuropsychological test results/reports
- Neuroeducational test results
- Academic records
- IEP records (w/standard test scores for latest testing)
- Standardized test records (for most recent testing)
- Conversation/Correspondence
- Psych/Beh Health recs
- Intake Summaries
- Discharge Summaries
- Treatment Plans
- Service agency records
- Legal records
- Medical records
- Neurology records
- MRI/Scan report(s)

The records to be disclosed are from the time period: **Case onset to present** **Other** ______________________

By signing below I authorize Counseling Resources Neuropsychological Associates, LLC to: (check all that apply)

Receive my health information/records from the following persons/entities:
Disclose my health information/records to the following persons/entities:

Name:_____________________________________ Ph:________________ Fax:________________

Address:____

Unless revoked by me in writing, this authorization will remain in effect until the following date or event: **12 months or case closure**

Patient Signature (if age 14 or above*): ______________________________________Date ______________

If patient is unable to sign or if patient is under age 18, complete the following:

Patient is unable to sign because: Minor Guardianship in Place Medical POA in Place

Authority of Personal Representative: Parent Guardian Health Care POA Other Authorization

Personal Rep Name & Address: ____

Personal Representative Signature: ___________________________________ Date______________

(*Note: If patient is age 14 to17 years, both the personal representative and adolescent signatures are required for authorization.)