NEUROPSYCHOLOGICAL ASSOCIATES OF CALIFORNIA

1260 North Dutton Ave., Ste. 225 Santa Rosa, CA 95401
707-526-5424 Fax 707-526-5900

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Patient Full Name) **(Patient Date of Birth)**
hereby authorize the release of my health information

To: / From:

Name: Neuropsychological Associates of California_____
Address: 1260 North Dutton Avenue Ste # 225
City, State, Zip: Santa Rosa, CA 96501_____

From: / To:

Name: _____
Address: _____
City, State, Zip: _____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Information requested: Pertinent medical history including imaging films and results, treatment notes, and lab work.

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 1 year after the date signed. The requestor should not redisclose my medical record to another party without further written consent.

I will not hold Neuropsychological Associates liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking for clarification of the information therein.

Date: _____ Signature: _____
(Patient or Legal Representative)

Date: _____ Witness: _____