PATIENT AUTHORIZATION FOR RELEASE OF HEALTH RECORDS TO EXTERNAL PARTIES

I authorize Justin O'Rourke, Ph.D., ABPP, with Clinical Neuropsychology of Texas, PLLC, to disclose the records of:

Examinee Name:____ **Date of Birth:**___________________

1. RECIPIENT

The information is to be disclosed to: ____
(person to receive the records)

Address: ____

City, State, Zip: ____

Contact Person: ____

Phone/Fax: _______________________ E-mail Address (if applicable):______________________________________

I authorize this information to be disclosed in the following ways:

- ❑ Written/Photocopy/Paper
- ❑ Verbal
- ❑ Fax
- ❑ Email/Electronic Format — Note: Email is not completely secure or confidential. If you choose to communicate or receive medical documents by email, be aware that all emails are retained in the logs of our internet service providers. Others with access to your email will be able to view any emailed records or information.

2. INFORMATION TO BE RELEASED

Dates of Evaluation or Treatment: From: __________________________ To: _______________________

Purpose of the disclosure (e.g., continuity of care; personal records):____

Specific records to be disclosed:

- ❑ Progress Notes
- ❑ Discharge Summary
- ❑ Consultation Reports
- ❑ Records from other facilities
- ❑ NEUROPSYCHOLOGICAL REPORT
- ❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).

I give specific authorization to disclose the following information:

- ❑ HIV test results
- ❑ Drug and alcohol abuse treatment records
- ❑ Documentation of AIDS diagnosis
- ❑ Psychiatric/Mental Health treatment records

3. CONSENT

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Clinical Neuropsychology of Texas, PLLC, in writing. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or state privacy regulations. Unless revoked earlier, this authorization expires in one (1) year unless I specify another time. I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____________________________________ _____________________________________
Signature of Patient (or Patient Representative) Date

_____________________________________ _____________________________________
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient
Relationship to Examinee: