Blue Ridge Neuropsychological Associates, P.A.

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Authorization to Release Protected Information

(APA HIPAA Compliant: 4/03)

This form, when completed and signed by you, authorizes Blue Ridge Neuropsychological Associates, P.A. to release protected information from your clinical record to the person you designate.

I authorize **Blue Ridge Neuropsychological Associates. P.A.** to release the following information:

____

To only the following individuals or organizations:

Name: ________________________________

Address: ________________________________

____

I am requesting my psychologist release this information for the following reasons: ("at the request of the individual" is all that is required if you do not want to state a specific purpose.)

____

This authorization shall remain in effect until _____/______/______. Although you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. Further, I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Date: _____/______/______

________________________________ ________________________________

Signature of client or guardian Relationship of person signing

____

Witness