Blue Ridge
Neuropsychological
Associates, P.A.

6 Herman Avenue, Suite A
Asheville, NC 28803
(828) 684-9123
FAX: (828) 684-9383

Authorization to Release Protected Information

(APA HIPAA Compliant: 4/03)

I, _____ hereby authorize

_____

to release my confidential medical records to:

Blue Ridge Neuropsychological Associates, P.A.
P.O. Box 5922
Asheville, NC
28813-5922
FAX (828) 684-9383 [secure FAX server]

Purpose: To help with diagnosis and treatment planning

Although I have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address, my revocation will not be effective to the extent that the releasing parties have taken action in reliance on the authorization 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 information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information, and no longer protected by the HIPAA Privacy Rule.

Today's date: _____/_____/_____

Printed Full Name: _____

Birthdate: _____/_____/_____

_____ _____
Signature of client or guardian Relationship of person signing

_____
Witness