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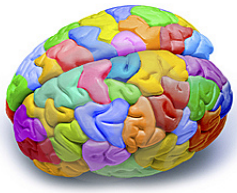

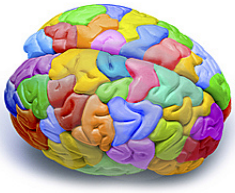

This form, when completed and signed by you, authorizes North Texas Neuropsychology & Behavioral Medicine Services to release protected information from your clinical record to the person(s) or entity(s) you designate and to obtain protected information from the person(s) or entity(s) you designate.

Patient's/Client's Name: _____

Date of Birth: _____ **Social Security #**: _____

I authorize the staff of North Texas Neuropsychology & Behavioral Medicine Services to release records or information, OR to obtain records or information regarding the above named person. These records may include any medical records, academic records, psychological or neuropsychological evaluations, treatment notes, diagnosis, recommendations, or any other information that is related to my care.

I authorize my records and information to be released to or obtained from the following individuals or entities:

Full Name: _____ Phone: _____

Address: _____ Fax: _____

Full Name: _____ Phone: _____

Address: _____ Fax: _____

Full Name: _____ Phone: _____

Address: _____ Fax: _____

Full Name: _____ Phone: _____

Address: _____ Fax: _____

Full Name: _____ Phone: _____

Address: _____ Fax: _____

This authorization shall remain in effect for one year from the date of signing or until _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. 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.

_____ _____

Signature of Patient or Guardian Date

If signed by a guardian, please state legal basis for guardian status: _____