TRIANGLE NEUROPSYCHOLOGY SERVICES, PLLC
3310 Croasdaile Drive, Suite 400, Durham, NC 27705
1540 Sunday Drive, Suite 200, Raleigh, NC 26707

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, and/or family members to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Triangle Neuropsychology Services PLLC to release any other information to these family members.

You have the right to revoke this consent in writing at any time in the future.

I **authorize/allow Triangle Neuropsychology Services PLLC to release information: _____ (initials) medical information or _____ (initials) billing information to the following individual(s):**

1. Name: _____

Contact Number: _____ Relation to Patient: _____

2. Name: _____

Contact Number: _____ Relation to Patient: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS AND/OR ON AN ANSWERING MACHINE OR VOICEMAIL

Occasionally it is necessary for the staff of Triangle Neuropsychology Services PLLC to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the client that the medical staff would like to discuss or schedule test results, and/or to ask a patient to call regarding an issue or concern. At no time will a representative of Triangle Neuropsychology Services PLLC discuss your medical condition to others without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

I authorize/allow Triangle Neuropsychology Services PLLC to leave messages with members of my household and on my answering machine or voicemail:

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

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AUTHORIZATION FOR A FAMILY MEMBER TO PARTICIPATE IN AN APPOINTMENT REGARDING NEUROPSYCHOLOGICAL INTAKE AND FEEDBACK OR PSYCHOTHERAPY

Some of our patients allow family members such as their spouse, parents, and/or others to participate in an appointment regarding intake and feedback information for neuropsychological testing and/or psychotherapy. These appointments may include discussion of personal health information. Signing this form will only give the individual listed below consent to attend an appointment with you. This form does not give an individual consent to talk to the doctor about your personal health information without you present.

You have the right to revoke this consent in writing at any time in the future.

I authorize/allow the following individual(s) to attend an intake, feedback, and/or psychotherapy appointment with me present at Triangle Neuropsychology Services PLLC:

1. Name: _____

Contact Number: _____ Relation to Patient: _____

2. Name: _____

Contact Number: _____ Relation to Patient: _____

I authorize/allow the following individual(s) to attend an intake and/or feedback meeting WITHOUT me present at Triangle Neuropsychology Services PLLC:

Name: _____

Contact Number: _____ Relation to Patient: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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