TRIANGLE NEUROPSYCHOLOGY SERVICES, PLLC

1520 Sunday Drive, Suite 320, Raleigh, NC 26707

AUTHORIZATION TO RECEIVE PROTECTED HEALTH INFORMATION

I authorize and request

Doctor/Medical Facility Name: _____

Address: _____

Phone: _____ Fax: _____

to release the following information from the medical records or disclose personal health information for:

Patient Name: _____

Date of Birth: _____ SS#: _____

This information should be released to:

Triangle Neuropsychology Services, PLLC Phone: 919-384-9682 Fax: 919-384-9683

Check if Applicable for Authorization: _____ Phone/Oral Communication, _____ Fax, _____ Electronic Access

Information to be disclosed:

_____ Current medical report, _____ Clinic notes, _____ Entire record,

_____ Other (specify):_____

The Information to be disclosed will be used for the following purpose:

_____ Physician for continuing care, _____ Insurance processing, _____ Legal reasons,

_____ Sharing with other providers, _____ Personal use,

_____ Other: _____

_____ I understand that information relevant to HIV testing or AIDS-related diagnosis, substance abuse and treatment, mental health and/or psychiatric information, or drug test results may be contained in this information.

This Authorization shall cover actions by and for Triangle Neuropsychology Services, PLLC and all of their respective employees and business associates. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to Triangle Neuropsychology Services, PLLC. Such revocation shall not affect disclosures made prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I understand authorizing the disclosure of the information identified above is voluntary, and this Authorization Is not intended to alter the patient's ability to receive medical care from any health care provider. This Authorization will automatically expire one year from the date signed or upon the fulfillment of the above purposes on _____ / _____ / 20____.

_____ _____ _____

Signature of Patient** or Legal Representative** Date Time

_____ _____

Relationship to Patient*** Signature of Witness

***If you are signing this form on behalf of the Patient, you must state your relationship to the patient. If you are the Health Care Power of Attorney for a Patient, you must provide legal documentation to this effect.

**If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, legal guardian, or other person acting loco parentis who has the authority to act on the minor-Patient's behalf. By signing this form for someone else, you as the parent, legal guardian, a party acting as loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.