Tidal Neuropsychology, PLLC
Griffin Pollock Sutton, Ph.D., ABN, Psychologist
19 South Hampstead Village Drive ~ Post Office Box 970
Hampstead, North Carolina 28443
Phone: 910-803-1434 Fax: 855-672-7002
www.tidalneuropsych.com griffinpsutton@gmail.com

PATIENT/CLIENT DEMOGRAPHIC INFORMATION:

First Name: _____ Middle: _____ Last: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Sex: M F Age: _____
Cell Phone: (_____) _____-_____ SSN: _____-_____-_____ DOB: _____/_____/_____
Marital Status: Single Married Separated Divorced Other Name of Spouse/Partner: _____
Vocational Status: Employed Student Homemaker Retired Unemployed Disabled Other: _____
Primary Occupation (current or previous): _____

INFORMATION ABOUT REASON FOR VISIT:

Referred by: _____ Reason for referral: _____
Please check all that apply: ___ Work-related injury ___ Motor vehicle accident ___ Other accident
Date of the incident: _____/_____/_____ Brief description of incident: _____
Are you represented by an attorney? Y N If *yes*, name: _____

FINANCIAL/INSURANCE INFORMATION:

Name of Responsible Party: _____ Relationship to Patient/Client: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Age: _____
Cell Phone: (_____) _____-_____ SSN: _____-_____-_____ DOB: _____/_____/_____
Employer's Name: _____ Employer's Phone: (_____) _____-_____
Employer's Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:
Primary Insurance: _____ Insured's Name: _____
Relationship to Patient/Client: _____ DOB: _____/_____/_____

Secondary Insurance: _____ Insured's Name: _____
Relationship to Patient/Client: _____ DOB: _____/_____/_____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Griffin Pollock Sutton, Ph.D., ABN to furnish information to insurance carriers and in such cases, to my others, as applicable, or to the Center for Medicare and Medicaid services and its agents concerning my illness and treatments. I hereby authorize payments for health services rendered to myself or authorize Medicare benefits, if applicable, to be made either to me or on my behalf to the above mental health provider. I understand that I am responsible for any amount not covered or reimbursed by insurance.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Signature of Insured Date

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INFORMED CONSENT FORM
PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING

Please read the following document in its entirety, as it contains important information regarding your neuropsychological evaluation with Griffin P. Sutton, Ph.D., ABN. Please sign on the designated line at the end of the document to indicate that you have reviewed and understand this information. If a patient is younger than 18 years of age, and/or if the patient has a legal guardian or custodian, the legal guardian/custodian of the patient must read and sign this form.

Purpose:
The purpose of a neuropsychological evaluation is to assess brain-behavior relationships. The obtained information will aid in diagnostic clarification and help guide treatment planning.

Procedure:
Clinical Interview: The neuropsychological evaluation will involve an interview of the patient, with possible additional interviews of the patient's significant other(s) with the patient's consent. While interview times vary, most interviews occur within the initial one-hour consultation; however, some interviews may last up to three hours in length. Topics to be included in the interview include: background/demographic information; family history; medical history; mental health concerns; educational history; employment history; and, a mental/neurobehavioral status examination. The interview will be conducted by Dr. Sutton.

Review of Relevant Records: Any relevant records (e.g., educational, medical, mental health, legal) provided to will be reviewed and considered when Dr. Sutton is conceptualizing the case.

Testing: If warranted, Dr. Sutton will recommend that the patient undergo testing, during which time tests designed to measure one's cognitive and emotional functioning will be administered to the patient. This occurs on a separate date than that of the initial interview. Testing may last anywhere from one to six hours in duration and may occur across one or multiple days, depending on the patient's wishes. Testing will also be completed by Dr. Sutton. Tests are in paper/pencil and oral format, with a handful of computer tests also included in some cases. It is important to note that testing will include several validity measures, which are designed to measure whether the patient is giving his/her best effort. It is therefore extremely important that the patient does provide his/her best effort, as not doing so may cloud the findings and limit the interpretations and recommendations.

Confidentiality:
As required by law and ethical guidelines set forth by both North Carolina and the American Psychological Association Ethical Principles for Psychologists and Code of Conduct, all information disclosed during the evaluation (i.e., via interview, review of records, testing, etc.) will be kept private and protected. Information that is shared will be kept strictly confidential and will not be disclosed without the patient's written consent. By law, however, confidentiality is not guaranteed in the following situations: (1) when the patient directs Dr. Sutton to tell someone else, in writing, about the evaluation; (2) if Dr. Sutton determines that the patient is a danger to himself/herself and/or others; (3) if Dr. Sutton is ordered by the court or law to disclose the information; (4) if Dr. Sutton suspects that child abuse/neglect has occurred; and, (5) if the insurance company of the responsible party requests that information.

Complaints:
In the event that you are dissatisfied with the services provided by Dr. Sutton for any reason, please do not hesitate to contact Dr. Sutton to let her know. If you would like to submit a comment, concern, or complaint about the privacy practices at Tidal Neuropsychology, PLLC, you can do so by sending a letter outlining your concerns to:

Griffin P. Sutton, Ph.D., ABN
Tidal Neuropsychology, PLLC
P.O. Box 970 Hampstead, NC 28443
(910) 803-1434

In the event that Dr. Sutton is unable to alleviate or resolve your concerns, you may report your complaint in writing to the North Carolina Psychology Board at:

North Carolina Psychology Board
895 State Farm Road Boone, NC 28607
(828) 262-2258

Freedom to Withdraw:
The patient has the right to discontinue the evaluation at any time. If the patient so desires, Dr. Sutton is able to provide the names of other qualified professionals that may help in completing the evaluation.

Informed Consent:
I, the patient/legal guardian/legal custodian, have read and understood the preceding statements. I have had an opportunity to ask questions about the statements and have had my questions answered, and I give consent for psychological/neuropsychological testing.

I have discussed with Dr. Sutton the various aspects of the evaluation. This has included a discussion of the preliminary evaluation and diagnostic formulation, as well as the proposed method of treatment. The nature of this treatment has been described, including any possible side effects and possible alternative treatments. I understand the limits to confidentiality, the scheduling policy, the fee policy, the policy regarding missed or cancelled appointments, and the emergency procedures.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Signature of Griffin Pollock Sutton, Ph.D., ABN, Psychologist Date

Tidal Neuropsychology, PLLC
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INFORMED CONSENT FORM:
PSYCHOLOGICAL/NEUROPSYCHOLOGICAL INTERVENTION

Please read the following document in its entirety, as it contains important information regarding your neuropsychological evaluation with Griffin P. Sutton, Ph.D., ABN. Please sign on the designated line at the end of the document to indicate that you have reviewed and understand this information. If a patient is younger than 18 years of age, and/or if the patient has a legal guardian or custodian, the legal guardian/custodian of the patient must read and sign this form.

Purpose:
The patient will undergo a mutually-agreed upon intervention plan which may aid in symptom reduction.

Procedure:
The goal of the intervention plan is to try to reduce symptoms. The goals of therapy will be agreed upon by Dr. Griffin P. Sutton and the patient at the outset of treatment, though goals may change over time. Intervention may include:

Psychotherapy: Psychotherapy is generally comprised of regularly scheduled sessions (generally weekly or monthly, depending on the individual needs of the client). While psychotherapy usually occurs on an individual basis, family members and/or significant others may be included on occasion when doing so may help the individual maximally benefit from the intervention. Psychotherapy generally lasts up to 12 weeks, and in some cases longer.

Cognitive Rehabilitation: Cognitive rehabilitation is generally comprised of regularly scheduled sessions (generally weekly or monthly, depending on the individual needs of the client). The goal of cognitive rehabilitation is most often to improve cognitive functioning, most typically through memory retraining and introduction of targeted memory strategies.

Confidentiality:
As required by law and ethical guidelines set forth by both North Carolina and the American Psychological Association Ethical Principles for Psychologists and Code of Conduct, all information disclosed during the evaluation (i.e., via interview, review of records, testing, etc.) will be kept private and protected. Information that is shared will be kept strictly confidential and will not be disclosed without the patient's written consent. By law, however, confidentiality is not guaranteed in the following situations: (1) when the patient directs Dr. Griffin P. Sutton to tell someone else, in writing, about the evaluation; (2) if Dr. Griffin P. Sutton determines that the patient is a danger to himself/herself and/or others; (3) if Dr. Griffin P. Sutton is ordered by the court or law to disclose the information; (4) if Dr. Griffin P. Sutton suspects that child abuse/neglect has occurred; and, (5) if the insurance company of the responsible party requests that information.

Complaints:
In the event that you are dissatisfied with the services provided by Dr. Griffin P. Sutton for any reason, please do not hesitate to contact Dr. Griffin P. Sutton to let her know. If you would like to submit a comment, concern, or complaint about the privacy practices at Tidal Neuropsychology, PLLC, you can do so by sending a letter outlining your concerns to:

Griffin P. Sutton, Ph.D., ABN
Tidal Neuropsychology, PLLC
P.O. Box 970 Hampstead, NC 28443
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In the event that Dr. Griffin P. Sutton is unable to alleviate or resolve your concerns, you may report your complaint in writing to the North Carolina Psychology Board at:

North Carolina Psychology Board
895 State Farm Road Boone, NC 28607
(828) 262-2258

Freedom to Withdraw:
The patient has the right to discontinue the intervention at any time. If the patient so desires, Dr. Griffin P. Sutton is able to provide the names of other qualified professionals that may help in providing an intervention program for the patient.

Informed Consent:
I, the patient/legal guardian/legal custodian, have read and understood the preceding statements. I have had an opportunity to ask questions about the statements and have had my questions answered, and I give consent for psychological/neuropsychological intervention.

I have discussed with Dr. Griffin P. Sutton the various aspects of the intervention. This has included a discussion of the preliminary evaluation and diagnostic formulation, as well as the proposed method of treatment. The nature of this treatment has been described, including any possible side effects and possible alternative treatments. I understand the limits to confidentiality, the scheduling policy, the fee policy, the policy regarding missed or cancelled appointments, and the emergency procedures.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Signature of Griffin Pollock Sutton, Ph.D., ABN, Psychologist Date

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NOTICE OF PRIVACY PRACTICES

The following describes the ways Tidal Neuropsychology, PLLC may use and disclose PHI. Except for the purposes described below, Tidal Neuropsychology, PLLC will use and disclose PHI only with the individual's written permission. The individual may revoke such permission at any time by writing to Tidal Neuropsychology, PLLC's Compliance Officer.

Assessment and Treatment:
Tidal Neuropsychology, PLLC may use and disclose PHI for the individual's treatment and to provide the individual with treatment-related health care services. For example, Tidal Neuropsychology, PLLC may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside Tidal Neuropsychology, PLLC's office, who are involved in the individual's medical care and need the information to provide the individual with medical care.

Payment:
Tidal Neuropsychology, PLLC may use and disclose PHI so that it may bill and receive payment from the individual, an insurance company, or a third party for the treatment and services the individual received. For example, Tidal Neuropsychology, PLLC may tell the individual's insurance company about a treatment the individual is going to receive to determine whether the individual's insurance company will cover the treatment.

Health Care Operations:
Tidal Neuropsychology, PLLC may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all patients receive quality care and to operate and manage Tidal Neuropsychology, PLLC's office. For example, Tidal Neuropsychology, PLLC may share information with other employees for quality assurance and educational purposes. Tidal Neuropsychology, PLLC also may share information with other entities that have a relationship with the individual (e.g., the individual's insurance company and anyone other than the individual who pays for the individual's services) for the individual's health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services:
Tidal Neuropsychology, PLLC may use and disclose PHI to contact the individual to remind them of an appointment. PHI may also be used and disclosed to tell the individual about treatment alternatives or health-related benefits and services that may be of interest.

Research
Under certain circumstances, Tidal Neuropsychology, PLLC may use and disclose PHI for research. For example, a research project may evolve comparing the health of patients who received one treatment to those who received another, for the same condition. Tidal Neuropsychology, PLLC will generally ask for the individual's written authorization before using the individual's PHI or sharing it with others to conduct research. Under limited circumstances, Tidal Neuropsychology, PLLC may use and disclose PHI for research purposes without the individual's permission. Before Tidal Neuropsychology, PLLC uses or discloses PHI for research without the individual's permission, the project will go through a special approval process to ensure that research conducted poses minimal risk to the individual's privacy. The individual's

information will be de-identified. Researchers may contact the individual to see if the individual is interested or eligible to participate in a study.

As Required by Law:
Tidal Neuropsychology, PLLC will disclose PHI when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety:
Tidal Neuropsychology, PLLC may use and disclose PHI when necessary to prevent a serious threat to the individual's health and safety or the health and safety of others. Disclosures, however, will be made only to someone who may be able to help prevent or respond to the threat, such as law enforcement or a potential victim. For example, Tidal Neuropsychology, PLLC may need to disclose information to law enforcement when a patient reveals intent to participate in a violent crime.

Business Associates:
Tidal Neuropsychology, PLLC may disclose PHI to its business associates that perform function on its behalf or provide Tidal Neuropsychology, PLLC with services if the information is necessary for such functions or services. For example, Tidal Neuropsychology, PLLC may use another company to perform billing services on Tidal Neuropsychology, PLLC's behalf. All of Tidal Neuropsychology, PLLC's business associates are obligated to protect the privacy of the individual's information and are not allowed to use or disclose any information other than as specified in our contract.

Workers' Compensation:
Tidal Neuropsychology, PLLC may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks:
Tidal Neuropsychology, PLLC may disclose PHI for public health risks or certain occurrences. These risks and occurrences generally include the report of child, elder, or dependent adult abuse or neglect; and, the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure when required or authorized by law).

Health Oversight Activities:
Tidal Neuropsychology, PLLC may disclose PHI to a health oversight agency, such as the North Carolina Department of Health and Human Services or Center for Medicare and Medicaid Services, for activities authorized by law, including, for example, audits, investigations, inspections, and licensure, and are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes:
Tidal Neuropsychology, PLLC may use or disclose the individual's PHI to provide legally required notices of unauthorized access to or disclosure of PHI.

Lawsuits and Disputes:
If the individual is involved in a lawsuit or a dispute, Tidal Neuropsychology, PLLC may disclose PHI in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell the individual about the request or to allow the individual to obtain an order protecting the information requested.

Law Enforcement
Tidal Neuropsychology, PLLC may release PHI to law enforcement agencies without your permission in

order to support government audits and inspections, to facilitate law enforcement investigations, for the protection of yourself and others, and to comply with mandated government reporting, as required by law.

National Security and Intelligence Activities
Tidal Neuropsychology, PLLC may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law, including disclosure of PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody:
If the individual is an inmate of a correctional institution or under the custody of a law enforcement official, Tidal Neuropsychology, PLLC may release PHI to the correctional institution or law enforcement official. This release would be necessary under the following circumstances: (1) for the institution to provide the individual with health care; (2) to protect the individual's health and safety or the health and safety of others; or, (3) for the safety and security of the correctional institution.

Note: Other uses and disclosures of PHI not covered by this Notice of Privacy Practice or the laws that apply to Tidal Neuropsychology, PLLC will be made only with the individual's written authorization. If the individual gives us authorization, the individual may revoke it at any time by submitting a written revocation to the Tidal Neuropsychology, PLLC Compliance Officer and we will no longer disclose PHI under the authorization. However, disclosure that Tidal Neuropsychology, PLLC made in reliance on an individual's authorization before the individual revoked it will not be affected by the revocation.

Individual's Rights Regarding PHI
The individual has certain rights under federal privacy standards. These individual rights include the following:
- The right to inspect and copy your PHI. Please note that such a request must be made in writing; please see us for a form to request to inspect and/or copy your PHI.
- The right to receive notification if a breach of your PHI occurs.
- The right to request an amendment, correction, or addendum to your PHI.
- The right to request an accounting of how, to whom, and for what purpose your PHI has been disclosed.
- The right to request a restriction or limitation on the use and disclosure of your PHI.
- If the individual pays out-of-pocket (versus billing the individual's health plan) in full for a specific item or service, the right to ask that the individual's PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to receive a paper copy of this Notice of Privacy Practices.

Additional Rights as Required by 10A NCAC 27D.0201
- The right to consent to or refuse evaluation and/or treatment.
- The right to dignity.
- The right to privacy.
- The right to humane care.
- The right to freedom from behavioral, mental, and physical abuse, neglect, and exploitation.
- The right to treatment, including access to medical/health care and habilitation, regardless of age or degree of MH/IDD/SA disability.
- The right to an individualized written treatment or habilitation plan.
- The right to confidentiality.
- The right to be informed of the potential risks and benefits of treatment.

Changes to this Notice of Privacy Practices

Tidal Neuropsychology, PLLC reserves the right to change this Notice of Privacy Practices and make the new Notice of Privacy Practices apply to PHI Tidal Neuropsychology, PLLC already has, as well as any information Tidal Neuropsychology, PLLC receives in the future. Tidal Neuropsychology, PLLC will post a copy of its current Notice of Privacy Practices at its office in such cases. The Notice of Privacy Practices will contain the effective date on the first page, in the top right-hand corner. Individuals will be asked to sign off on the new Notice of Privacy Practices at the individual's next scheduled appointment.

Complaints

If an individual believes their privacy rights have been violated, the individual may file a complaint with Griffin Pollock Sutton, Ph.D., ABN, HIPAA Compliance Officer, P.O. Box 970, Hampstead, NC, 28443, 910-803-1434. All complaints must be made in writing. Individuals may also contact the Secretary of the Department of Health and Human Services or Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Please contact the Tidal Neuropsychology, PLLC Compliance Officer if an individual needs assistance locating current contact information. Individuals will not be penalized or retaliated against for filing a complaint.

By signing below, I am hereby certifying that I have read, agreed to, and received a copy of the Notice of Privacy Practices for the office of Griffin Pollock Sutton, Ph.D., ABN, Tidal Neuropsychology, PLLC.

_____ _____

Signature of Client/Legal Guardian Date

Tidal Neuropsychology, PLLC
Griffin Pollock Sutton, Ph.D., ABN, Psychologist
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Hampstead, North Carolina 28443
Phone: 910-803-1434 Fax: 855-672-7002
www.tidalneuropsych.com griffinpsutton@gmail.com

PAYMENT POLICY

Cancellation Policy:
A minimum of 48 hours of notice is required for cancellation of appointments. If this notice is not received, you may be charged for the full amount of time that was reserved for your appointment. This may include legal fees associated with subpoenas, depositions, and other court-related activities. Insurance cannot be billed for missed or cancelled appointments.

Copayment:
Your copayment is expected at the time of service.

Insurance Filing and Coverage:
We will file our initial insurance claim(s) and provide the documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. You may incur extra charges for refiling of insurance claims. If a service is not covered, or is only partially covered according to our understanding of your insurance policy, the service may be provided to you as long as you understand that there is no or limited coverage, and that you will be responsible for the costs of the service.

Payment:
In the event that your insurance does not cover our services (or any portion thereof), we will work with you regarding payment (e.g., setting up a payment plan). We expect full payment within thirty days of the date of service. The undersigned hereby agrees that interest at 12% per annum may be due, and owing on this account and said interest may begin thirty days after the principal is due. You bear ultimate financial responsibility for all services rendered to you, including workers' compensation claims and personal injury cases, regardless of the outcome of litigation. In the event that coverage is denied under workers' compensation, you will pay the unpaid balance, notwithstanding any appeal of such denial. With respect to personal injury cases, you are responsible for fees incurred, we may not be able to seek payment from third parties, and we cannot wait on the outcome of pending litigation for payments. We do not accept contingency fee arrangements. If there is any remaining balance(s) due at the time of settlement, you hereby authorize your attorney to clear your outstanding accounts. Your signature also constitutes your irrevocable agreement to a waiver permitting payment of health insurance claims directly to Tidal Neuropsychology, PLLC prior to claimant receiving such funds.

Forensic Cases:
Responding to discovery requests, conferences, and phone calls with attorneys involve additional time and recordkeeping. Additionally, the patient or responsible party is responsible for all direct costs and expenses associated with Griffin P. Sutton, Ph.D., ABN, and the attorney or legal representative responding to discovery requests (including depositions) and with these conferences including, but not limited to, court appearances, preparation of reports, photocopying, faxes, long distance travel, telephone, overnight delivery, and courier services. These expenses are billed to the patient or responsible party and to the patient's attorney. The patient or responsible party, however, remains primarily responsible for payment of these charges if not paid in full within thirty days. Please note that testing includes time for (1) selection of tests, (2) administering of tests, (3) scoring of tests, (4) interpretation of tests, and (5) discussion of results (feedback). In certain cases (such as, but not limited to, medical-legal cases), a more comprehensive and time-consuming assessment may be needed than

what may be approved under your insurance plan. The responsible party, as noted below, accepts responsibility for these charges.

Guarantee of Payment and Assignment of Insurance Benefits:
For value received, the undersigned guarantor and/or patient (hereinafter referred to as "the Undersigned") promises to pay Griffin P. Sutton, Ph.D., ABN of Tidal Neuropsychology, PLLC (hereinafter referred to as "Provider") all charges incurred for the services rendered to the Undersigned. The Undersigned understands that the Provider will process the paperwork to complete insurance claim(s), but only as a courtesy to the Undersigned, and the Undersigned authorizes the Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by the Provider in the event insurance does not pay for these services. It is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Undersigned. It is further agreed upon by the Undersigned that if, in the event that any monies received by the Provider from the insurance carrier are at any time after their receipt withdrawn from the Provider by the insurance carrier, the Undersigned will be responsible for those monies that due and owing, and waives any defense for payment that the Undersigned may have against the Provider. In the event that this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs, but including reasonable attorney's fees. The Undersigned authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized.

Liability:
We will do everything possible to safeguard your safety. However, please note that once you are outside the confines of our office, we are no longer able to safeguard your safety.

If you have any questions, please speak to Dr. Griffin P. Sutton directly. Your signature below indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Signature of Griffin Pollock Sutton, Ph.D., ABN, Psychologist Date

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Hampstead, North Carolina 28443
Phone: 910-803-1434 Fax: 855-672-7002
www.tidalneuropsych.com griffinpsutton@gmail.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, _____
(print full name) (date of birth)

hereby authorize the release of my health information from Griffin Pollock Sutton, Ph.D., ABN, Tidal Neuropsychology PLLC, 19 South Hampstead Village Drive, Post Office Box 970, Hampstead, North Carolina, 28443 to the following recipient(s):

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

(Please use additional form for additional recipients.)

Purpose of disclosure: (If you are a registered patient and do not wish to specify a specific purpose, please write "at the request of the individual for coordination of care.")

_____

Information requested: _____

_____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information. Substance abuse information is protected per the confidentiality and disclosure requirements of 42 CFR Part 2. HIV/AIDS information is protected per the confidentiality and disclosure requirements under G.S. 130A-143.

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 365 days after the date signed. The requestor should not redisclose any medical record to another party without further written consent.

I will not hold Griffin Pollock Sutton, Ph.D., ABN nor Tidal Neuropsychology PLLC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Sutton for clarification of the information therein.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Signature of Witness Date

Tidal Neuropsychology, PLLC
Griffin Pollock Sutton, Ph.D., ABN, Psychologist
19 South Hampstead Village Drive ~ Post Office Box 970
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, _____
(print full name) (date of birth)

hereby authorize the release of my health information from Griffin Pollock Sutton, Ph.D., ABN, Tidal Neuropsychology PLLC, 19 South Hampstead Village Drive, Post Office Box 970, Hampstead, North Carolina, 28443 to the following recipient(s):

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

(Please use additional form for additional recipients.)

Purpose of disclosure: (If you are a registered patient and do not wish to specify a specific purpose, please write "at the request of the individual for coordination of care.")

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Information requested: _____

_____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information. Substance abuse information is protected per the confidentiality and disclosure requirements of 42 CFR Part 2. HIV/AIDS information is protected per the confidentiality and disclosure requirements under G.S. 130A-143.

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 365 days after the date signed. The requestor should not redisclose any medical record to another party without further written consent.

I will not hold Griffin Pollock Sutton, Ph.D., ABN nor Tidal Neuropsychology PLLC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Sutton for clarification of the information therein.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Signature of Witness Date

Tidal Neuropsychology, PLLC
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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(print full name) (date of birth)

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Name: _____

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City/State/Zip: _____

Phone: _____ Fax: _____

(Please use additional form for additional recipients.)

Purpose of disclosure: (If you are a registered patient and do not wish to specify a specific purpose, please write "at the request of the individual for coordination of care.")

_____

Information requested: _____

_____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information. Substance abuse information is protected per the confidentiality and disclosure requirements of 42 CFR Part 2. HIV/AIDS information is protected per the confidentiality and disclosure requirements under G.S. 130A-143.

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 365 days after the date signed. The requestor should not redisclose any medical record to another party without further written consent.

I will not hold Griffin Pollock Sutton, Ph.D., ABN nor Tidal Neuropsychology PLLC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Sutton for clarification of the information therein.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Signature of Witness Date