

CAMPBELL NEUROPSYCHOLOGICAL SERVICES, PC

Phone (515) 330-1114 ● Fax (515) 331-6565 ● 6200 Aurora Avenue, Suite 202W Urbandale, Iowa 50322

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

ONE PER REQUEST

Patient Full Name (PRINT) _____ DOB _____

Is requesting that Campbell Neuropsychological Services, P.C. release **TO** OR obtain **FROM** the person/company/agency/facility listed below:

Name, Position, or Department:
Name of Organization:
Address of Organization:
Phone Number of Organization:

The information to be disclosed relate to service dates beginning _____ and ending _____

<input type="checkbox"/> Medical/Surgical History	<input type="checkbox"/> Neuropsychological/Psychological Testing	<input type="checkbox"/> Face-to-Face Communication or Telephone Contact
<input type="checkbox"/> Physician Office Visits	<input type="checkbox"/> Neurological Consult Notes	<input type="checkbox"/> Other:
<input type="checkbox"/> Medication List	<input type="checkbox"/> Speech Therapy Notes	<input type="checkbox"/> Other:

The purpose of disclosure:

<input type="checkbox"/> Request of Individual	<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Other: _____
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In signing this form, I understand the following provisions:

This authorization for release expires **12 months** from the date of patient's signature. I have the right to revoke this authorization, in writing, at any time by sending such written notification to our office. However, my revocation will not be effective to the extent that Campbell Neuropsychological Services has taken action in reliance on the authorization prior to receipt of the revocation or if this authorization was obtained as a condition of securing insurance coverage and the insurer has a legal right to contest a claim.

I understand that Campbell Neuropsychological Services may not condition neuropsychological services upon my signing an authorization unless the neuropsychological services are provided to me for the purpose of creating health information for a third party.

I understand and acknowledge that this may include information regarding alcohol and/or drug abuse, mental health, or HIV/AIDS. I understand that I have the right to inspect and copy the disclosed mental health information at any time.

I understand that state law precludes redisclosure of any information.

SIGNED: _____ **DATE:** _____