CAMPBELL NEUROPSYCHOLOGICAL SERVICES, PC
Derek A. Campbell, Ph.D.
6200 Aurora Ave, Suite 202W
Urbandale, IA 50322
515-252-2522 (Voice)
515-252-2523 (Fax)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Full Name) (Date of Birth)
hereby authorize the release of my health information

from:

Derek A. Campbell, Ph.D. **6200 Aurora Ave, Suite 202W** **Urbandale, IA 50322**

to:

Clinical Psychologist/Lic#: _____ **Company/Organization: _____** **Address: _____** **City/State/Zip: _____** **FAX: _____**

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure:

☐ **Claim Processing**
☐ **Continuity of Care**

Information requested:

Report and "raw data" (includes your responses to questions and test sheets) from neuropsychological examination.

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 90 days after the date signed. The requestor should not redisclose my medical record to another party without further written consent.

Date: _____ Signature: _____
(Patient or Legal Representative)