Meredith Hickory, Psy.D. PLLC
Pediatric Neuropsychologist
891 Washington Street
Raleigh, North Carolina 27605
Telephone: 919.971.1495 drmeredithhickory@gmail.com

Consent to Release Medical Information

Name: _____Date of Birth:_____

Date(s) of Service_____

I authorize and request_____

to release my records, as indicated below to Meredith Hickory, Psy.D. PLLC:

_____ Complete copy of my medical records regarding my hospitalizations, treatment, or care.

_____ Educational information including all report cards, current IEP, and psychological or educational testing.

_____ Other (specify): _____

Please mail to the address above to the attention of: **Dr. Meredith Hickory**
drmeredithhickory@gmail.com 891 Washington Street
Raleigh, North Carolina 27605

I understand that personal health information disclosed may include information regarding psychological or psychiatric impairment, substance abuse, Acquired Immunodeficiency Syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). I understand that I may revoke this consent at any time except to the extent that the information has already been released pursuant to the consent and before I have revoked my consent. Otherwise, this consent shall continue to be valid for as long as reasonably necessary to carry out the purposes enumerated above, or for 90 days. I fully understand the nature of this release, any questions have been answered to my satisfaction, and I understand this authorization is voluntary.

_____ ____

Patient Signature (print name if patient has legal guardian or power of attorney) Date

_____

Representative's Signature (if patient has legal guardian or power of attorney) Date

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