NEUROPSYCH ASSESSMENTS
OF GREATER BOSTON

AUTHORIZATION FOR TESTING & RELEASE OF INFORMATION & COMMUNICATION

I/we, the legal guardian (s) of _____
am giving consent for Neuropsych Assessments of Greater Boston to evaluate my/our child. All parties who have legal custody have consented to this evaluation.

I understand that I may withdraw my authorization at any time by submitting a written request to Neuropsych Assessments of Greater Boston. Authorization may be withdrawn except for the following:

- to the extent that action has been taken in reliance on this authorization;
- if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the any information about, including reports of my child's condition to those persons or agencies listed.

I also authorize Neuropsych Assessments of Greater Boston to release such information as may be necessary, including sending a copy of the resulting written report to the following individuals, agencies or institutions:

Insurance ID# _____

Primary Care Physician (PCP)

Name: _____

Telephone # _____

Fax# _____

Address: _____

Teachers/ Therapists/ Other Providers

(1) Name: _____ **(2) Name:** _____

Position: _____ **Position:** _____

Tele# _____ **Tele#** _____

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Teachers/ Therapists/ Other Providers

(3) Name: _____ **(4) Name:** _____

Position: _____ **Position:** _____

Tele# _____ **Tele#** _____

PARENT/ GUARDIAN

(1) Signature: _____

Print name: _____

Relationship to Client/ child _____

Date:_____

Tele:_____

Address:_____

E-mail:_____

(2) Signature: _____

Print name: _____

Relationship to Client/ child _____

Date:_____

Tele:_____

Address:_____

E-mail:_____