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
Ph: (515) 252-2522
Fax: (515) 252-2523

to:

Name: _____
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: _____

Information requested: Report and/or feedback 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 re-disclose my medical record to another party without further written consent.

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