CAMPBELL NEUROPSYCHOLOGICAL SERVICES, PC

Phone (515) 330-1114 ● Fax (515) 331-6565 ● 2700 Westown Parkway, Suite 415 West Des Moines, Iowa 50266

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:	Fax Number of Organization:

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

☐ Medical/Surgical History	☐ Neuropsychological/Psychological Testing	☐ Face-to-Face Communication or Telephone Contact
☐ Physician Office Visits	☐ Neurological Consult Notes	☐ Other:
☐ Medication List	☐ Speech Therapy Notes	☐ Other:

The purpose of disclosure:

☐ Request of Individual	☐ Continuity of Care	☐ Other:_____

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 preludes redisclosure of any information.

SIGNED:_____ **DATE:**_____