Pathways Neuropsychology Associates | Health & Rehabilitation Services

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act (HIPPA)), 45 C.F.R., Parts 160 and 164)

Date:_____

Patient:_____ DOB:_____

1. **AUTHORIZATION: I authorize Pathways Neuropsychology Associates to use and disclose the protected health information described below to:**

   Physicians: _____
   _____
   _____

   Attorney: _____

   Other: _____

2. **EFFECTIVE PERIOD: This authorization for release of information covers the period of healthcare from:**

   _____ to _____ ****OR**** _____ all past, present & future periods

3. **EXTENT OF AUTHORIZATION:**

   _____**I authorize the release of my COMPLETE health record** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
   ****OR****
   _____**I authorize the release of my complete health record with the EXCEPTION of the following information:**
   _____ Mental Health Records ____ Communicable diseases
   _____ Alcohol/drug abuse treatment ____ Demographic information
   _____ Other (please specify_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment of consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time and this authorization will expire when treatment ends. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used to disclose pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that my records are protected under HIPAA State Confidentiality Regulations and cannot be disclosed without my written consent or otherwise provided for in the regulations.

(If patient is a minor (17 & under), both parents or guardians are required to sign this release. If the minor is 14-17 years of age their signature is *also* required.)

Signature of patient or personal representative _____ Date _____

Printed Name of patient or personal representative _____ Relationship to Patient _____

Signature of minor patient 14-17 _____ Date _____

"Dedicated to effective and compassionate care for individuals with neurological challenges."