Falls Neuropsychology and Psychotherapy Associates, PLLC

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Consent for Other Offices to Release Information and Records
to Falls Neuropsychology and Psychotherapy Associates, PLLC

I hereby authorize the release of information from the medical records of and/or disclosure of protected health information for:

Name: Social Security #: Date of Birth
_____/_____/_____

Purpose of Disclosure:

_____

Dates of Service:

_____

This information is to be released to Thomas Bundick, Ph.D. / Denise Bundick, LCSW / Tammy Bays Rose, LCSW (please circle) of Falls Neuropsychology and Psychotherapy Associates, PLLC.

I understand the 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 this consent before its revocation. Otherwise, this consent shall continue to be valid only as long as is reasonably necessary to carry out the purposes enumerated above or one year after the date signed, whichever is the earliest date.

_____/_____/_____
Patient/Representative Signature Relationship Date signed

If you signed as a representative of the patient, read the following and sign below:

I, _____, hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I have read the provisions set forth in this authorization, and agree that the recipient of this consent form may disclose the medical record information of such individual for the purposes set forth herein.

_____/_____
Signature Date signed

I understand that if information disclosed pursuant to this authorization is re-disclosed by me/us, that information would no longer be protected under the terms of the federal privacy rule.