Falls Neuropsychology and Psychotherapy Associates, PLLC

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Consent for FNPA to Release Your Information and Records

I, _____ (Date of Birth :_____), hereby authorize _____ of Falls Neuropsychology and Psychotherapy Associates, PLLC, to release my records and reports pertaining to my treatment, beginning with my first appointment on _____, to the following parties:

Name: Address:

_____

_____

_____

for the following purpose, use, or need:

- ☐ Coordination of treatment
- ☐ Provision of information to other professionals
- ☐ other _____

The following information from my records may be disclosed:

- ☐ General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, evaluation reports, treatment plans, global assessment of treatment progress)
- ☐ Psychotherapy notes
- ☐ Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until twelve months from the date of signature.

_____

Signature of Patient Date

_____

Witness Date

Consent by Person Other than Patient

If patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I, _____, certify that I am the _____ of the patient; that the patient is unable to consent because he or she is a minor, _____ years of age, or because _____.

_____

Signature of Parent or Guardian Date

_____

Witness Date