Developmental Discoveries
NEUROPSYCHOLOGY
www.developmental-discoveries.com

(763) 330-2730 (612) 677-3370 admin@developmental-discoveries.com
3030 Harbor Lane N, Suite 205 Plymouth, MN 55447

CONSENT FORM TO RELEASE HEALTH INFORMATION

_____ _____
(Name of Patient) (Date of Birth)

_____
(Home Address)

_____ _____
(E-mail- *optional*) (Phone number- *optional*)

THIS FORM WILL AUTHORIZE DEVELOPMENTAL DISCOVERIES NEUROPSYCHOLOGY TO EXCHANGE INFORMATION WITH:

_____ _____
(Name of Agency/Provider) (Attention to)

_____
(Address)

_____ _____
(E-mail and/or fax number) (Phone number)

THE FOLLOWING INFORMATION:

- ☐ Medical Records
- ☐ Speech/Language Evaluation
- ☐ Psychological Assessment
- ☐ Psychiatric Evaluation
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ General Communication
- ☐ School Records
- ☐ Achievement Testing
- ☐ Teacher Rating Scales
- ☐ 504 Plan or IEP
- ☐ Progress Reports
- ☐ Other: _____

The purpose of this information is for assessment and treatment planning, and/or continuity of care.
This authorization is valid for one year from the signature date, unless otherwise specified.

I/we understand that by signing this form, I/we am/are requesting that the specified health information be exchanged between Developmental Discoveries Neuropsychology and the individual/agency/organization detailed above. I/we understand that my/our records are protected under State and Federal confidentiality and data privacy regulations and cannot be disclosed without my/our written consent unless otherwise provided for in the regulations. I/we understand that this consent will end one year from the date the form is signed, except as otherwise allowed by law, or unless otherwise specified above. I/we understand that I/we may revoke this consent at any time by written request to Developmental Discoveries Neuropsychology. If Developmental Discoveries and/or the individual/agency/organization have already released health information based on my consent, my request to stop will not work for that health information. I/we understand that Developmental Discoveries Neuropsychology will not condition treatment, payment, enrollment or eligibility for benefits on whether I/we sign the consent form. I/we declare that by signing this form, I/we understand and have been told of the nature and purpose of this authorized release.

_____ _____
(Signature of Patient or Parent/Authorized Legal Representative) Date MM/DD/YYYY

_____ _____
(Print Name of Parent/Authorized Legal Representative if applicable) Relationship to Patient