Developmental Discoveries
NEUROPSYCHOLOGY
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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 RELEASE INFORMATION TO:

_____ _____
(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 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 sent from Developmental Discoveries Neuropsychology to 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 has 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