NEUROPSYCHOLOGICAL ASSOCIATES
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Full Name) (Date of Birth)
hereby authorize the release of my health information

from:

Name: _____
Address: _____
City, State, Zip: _____

to:

Name: _____
Address: _____
City, State, Zip: _____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: _____

Information requested: _____

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 1 year after the date signed. The requestor should not redisclose my medical record to another party without further written consent.

I will not hold Dr. Michael Fraga nor the Neuropsychological Associates liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Michael Fraga for clarification of the information therein.

Date: _____ Signature: _____
(Patient or Legal Representative)

Date: _____ Witness: _____