North Penn Neuropsychological Services

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Authorization to Release Information to North Penn Neuropsychological Services

Please use this form if you are giving someone else permission to speak with (or provide medical records to) North Penn Neuropsychological Services.

Patient Name _____ Date of Birth_____

Address _____

_____

Phone _____

I authorize _____ to release information to:

___North Penn Neuropsychological Services_____

___1012 N. Bethlehem Pike, Suite 103_____

___Lower Gwynedd, PA 19002_____

for the period of ___1 year_____.

This information is limited to: Information essential for Psychological Services, Psychiatric Services, and Neuropsychological Evaluation Services (including, but not limited to office notes, radiology reports, labs, previous testing, hospital records, medication records, discharge records and psychological / psychiatric records).

I understand this information is confidential and I have the right to review or revoke this authorization at any time either verbally or in writing.

This authorization is in-compliance with the Pennsylvania Mental Health Procedures Act section 7100.111.3, the Pennsylvania Drug and Alcohol Abuse Control Act and Act 52 of Pennsylvania State Psychology Board.

I understand the contents of this authorization and I understand my rights.

Patient Signature (if minor, write "minor") _____ Date_____

Parent/Guardian Signature (for minor patient) _____ Date_____