Middle Tennessee Neuropsychological & Behavioral Medicine Services

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AUTHORIZATION TO EXCHANGE INFORMATION

This form, when completed and signed, authorizes Middle Tennessee Neuropsychology & Behavioral Medicine Services, PLLC, or an agent of the practice, to release protected information from your clinical record to the person you designate (Part B) or for the person you designate (Part A) to release information about you to Middle Tennessee Neuropsychology & Behavioral Medicine Services, PLLC. You have a right to request and receive a copy of this completed authorization. Please note that your signature allows copies of this form to be treated like originals. This means that signed copies of this form have the same legal obligation and force as the original signed document.

Patient Name: _____ DOB: _____ DOE: _____

PART A I authorize Middle Tennessee Neuropsychological & Behavioral Medicine Services, PLLC to **RECEIVE** records from the following individual or organization (or their agent):

Name: _____

Address: _____

Phone#: _____ Fax#: _____

Information to be disclosed:

□ Medical records □ Legal records □ School records

□ Diagnostic/psychological tests □ Treatment records/reports □ Employment records

□ Other: _____
(description of information to be enclosed)

PLEASE CHECK BOXES:

□ Yes □ No I authorize the disclosure of information related to HIV/AIDS status or treatment.

□ Yes □ No I authorize the disclosure of information related to alcohol/drug abuse or treatment.

□ Yes □ No I authorize the disclosure of information related to mental health diagnosis or treatment.

PART B I authorize Middle Tennessee Neuropsychological & Behavioral Medicine Services, PLLC to **RELEASE** records to the following individual or organization (or their agent):

Name: _____

Address: _____

Phone#: _____ Fax#: _____

Information to be released:

□ Neuropsychological report

□ Other: _____
(description of information to be enclosed)

PLEASE CHECK BOXES:

□ Yes □ No I authorize the disclosure of information related to HIV/AIDS status or treatment.

□ Yes □ No I authorize the disclosure of information related to alcohol/drug abuse or treatment.

□ Yes □ No I authorize the disclosure of information related to mental health diagnosis or treatment.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that any of the persons or agencies named above have already taken action on the authorization. You should be aware that your revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

- I understand that I may refuse authorization to disclose all or some of the requested healthcare information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA Privacy Rule.
- I agree to the release of the above information, that the nature of this information has been discussed with me in a manner that I understand, and that I have had an opportunity to have any questions regarding the above release of information answered for me.

Signature of Patient or Guardian: _____ Date: _____

Printed Name of Patient: _____

Patient Date of Birth: _____ Patient SSN: _____

Printed Name of Guardian (if relevant): _____