NEUROPSYCHOLOGY CENTER OF MARYLAND LLC
Aaron N. Juni, Ph.D.
Clinical Neuropsychologist
2501 Smith Avenue, Baltimore MD 21209
Ph: (443) 379 – 0033 Fax (443) 213 – 1502
Email: draaronjuni@gmail.com web: www.mdneuropsych.com

EXCHANGE OF RECORDS

PATIENT NAME: ______________________________ DOB: ____________
ADDRESS: ______________________________ PHONE: (_____) ____________

This form authorizes exchange of protected health information between Dr. Juni and the entities listed below:

Name: ______________________
Phone: __________ Fax: __________
Address: ______________________
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Name: ______________________
Phone: __________ Fax: __________
Address: ______________________
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Name: ______________________
Phone: __________ Fax: __________
Address: ______________________
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Name: ______________________
Phone: __________ Fax: __________
Address: ______________________
____

The following information may be released:

- ❑ Assessment Results
- ❑ Evaluation Report
- ❑ Diagnostic Information
- ❑ Treatment Notes
- ❑ Summary of Clinical Findings
- ❑ Any necessary information

I am requesting that this information be shared for the following reasons:

❑Treatment Planning ❑Billing ❑Updates ❑Other: ______________

This authorization shall remain in effect until __________ or for 12 months from the date of signature.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the Neuropsychology Center of Maryland. I understand that revocation will not be effective to the extent of any action already taken in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my clinician may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and thus may no longer be protected by HIPAA Privacy Rules.

______________________ ______________________ __________
Signature of Client Printed Name Date

______________________ ______________________ __________ __________
Signature of Parent or Guardian (if needed) Printed Name Relationship Date

______________________ ______________________ __________
Signature of Witness Printed Name Date