

NEUROPSYCHOLOGY CENTER OF MARYLAND LLC

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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: _____

Name: _____
Phone: _____ Fax: _____
Address: _____

Name: _____
Phone: _____ Fax: _____
Address: _____

Name: _____
Phone: _____ Fax: _____
Address: _____

The following information may be released:			
<input type="checkbox"/> Assessment Results	<input type="checkbox"/> Evaluation Report	<input type="checkbox"/> Diagnostic Information	
<input type="checkbox"/> Treatment Notes	<input type="checkbox"/> Summary of Clinical Findings	<input type="checkbox"/> Any necessary information	
I am requesting that this information be shared for the following reasons:			
<input type="checkbox"/> Treatment Planning	<input type="checkbox"/> Billing	<input type="checkbox"/> Updates	<input type="checkbox"/> 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