



Center for Brain Health, Inc.

Mail all Forms to: Center for Brain Health, Inc.
PO Box 956
Oldsmar, FL 34677
(Phone) (727) 771-9603

Fax copy to: (727) 771-9603
facsimile or copies to be
honored as originals.

Patient Name: _____ SSN/ID _____ DOB _____

AUTHORIZATION FOR CENTER FOR BRAIN HEALTH, INC. TO RELEASE CONFIDENTIAL PSYCHOLOGICAL INFORMATION TO OUTSIDE AGENCIES, FACILITIES, OR INDIVIDUALS

This form when completed and signed by you, authorizes us to release protected and/or confidential psychological information from our clinical record to the person or agencies you designate. You agree and understand that this form does not constitute a general release, and that by checking off or specifying information below you are agreeing to an informed release of specific sensitive and confidential information. You also agree that we are not responsible for and cannot control any further release by the agencies or individuals this information is sent to.

I authorize Center for Brain Health, Inc. and/or its administrative and clinical staff to release the following individually checked items in their entirety or additional information as indicated below:

- Psychological and Neuropsychological Testing Reports (raw testing data will only be released to a Licensed Psychologist)
- Discharge/Treatment Summary

This authorization shall authorize for release of information from _____ to _____ or for 120 days from the date of signature if not specified.

This release shall authorize release of the above specified information to the following individuals or agencies:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____ (fax)	_____ (fax)	_____ (fax)

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 we or the receiving agencies or individuals have taken action 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. By signing below you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

Signature of Patient or Authorized Representative _____ Date _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.