Children's Neuropsychological Services, PLLC
834 Kenwood Ave., Suite 3
Slingerlands, NY 12159
Phone: 518-439-1641
Fax: 518-439-1625
www.ChildrensNeuroServices.com

CONSENT TO OBTAIN/DISCLOSE INFORMATION

Patient Name_____ **Date of Birth**_____

Address_____

Phone_____

I authorize Children's Neuropsychological Services, PLLC to (Check all that apply)**:**

____obtain medical and/or academic information from

____give information to

____both obtain information from and give information to

____send report to

____invite advocate or attorney to the feedback session, if applicable

Name_____

Address_____

Fax #_____ **(if doctor's office)**

for the purpose of neuropsychological evaluation of my child or myself (if adult patient). I understand that if this authorization is for the purpose of giving information, all diagnostic and therapeutic information may be included, with the following exception(s) (Check all that apply):

____no exceptions

____treatment for alcohol and drug abuse

____specific diagnostic information (specify: _____)

____specific treatment information (specify: _____)

____other (specify: _____)

This authorization may be revoked at any time except to the extent that action has already occurred in reliance thereupon.

This authorization shall be valid for (90) days unless otherwise specified.

Signature of patient/parent/guardian _____ Date_____

Relationship to patient_____

Any redisclosure of medical record information by the recipient(s) is prohibited in connection with the further care of the patient and used solely for his or her benefit. If drug abuse or alcohol records are involved here, this information is disclosed from records from which confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibit redisclosure without specific written consent, of the persons to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information will not be sufficient for this purpose.