Neponset Valley Neuropsychology, LLC.
45 Walpole Street – Suite 6
Norwood, MA 02062
Tel: (781) 769-1646 **Fax: (781) 769-4696**

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

I hereby authorize Neponset Valley Neuropsychology, LLC. to (**check all that apply**):

_____ TO **RELEASE** COPIES OF MY MEDICAL RECORDS FROM:

(For receiving providers: Please send most recent office notes and any neuroimaging reports to our office for review.)

_____ TO **RELEASE** COPIES OF MY NEUROPSYCHOLOGICAL REPORT TO:

Primary Care Provider (PCP): _____ Phone: _____

Additional Provider: _____ Phone: _____

Additional Provider: _____ Phone: _____

Other: _____ Phone: _____

I hereby authorize Neponset Valley Neuropsychology, LLC. to discuss all details related to my evaluation and care with:

Family: _____ Phone: _____

Other: _____ Phone: _____

I understand that once Neponset Valley Neuropsychology, LLC, discloses my health information to the recipient, Neponset Valley Neuropsychology, LLC, cannot guarantee that the recipient will not disclose my health information to another party. I have read and understand the terms of this authorization. By my signature below, I hereby knowingly and voluntarily authorize Neponset Valley Neuropsychology, LLC, to use or disclose my health information in the manner described above.

_____
Signature of patient

Date: _____
Authorized signature valid for 2-years from printed date

_____
Signature of patient's legal guardian/representative

Date: _____
Authorized signature valid for 2-years from printed date