Empire Neuropsychological Services, PLLC

Jodie Cohen, PhD

200 Delaware Avenue, Delmar, NY 12054 ✦ t: (518) 123-4567 ⋄ f: (518) 621-0761

PROTECTED HEALTH INFORMATION RELEASE ACCESS REQUEST FORM

I hearby authorize Jodie Cohen Pediatric Neuropsychological Services, PLLC to disclose **AND/OR [circle one]** receive records for:

Patient/Client Name:_____ DOB:_____

From/To:_____ Phone:_____

Address:_____ Fax:_____

The following information [check all that apply]:

___ Speech Evaluation ___ Psychological Evaluation _ Other _____

___ OT Evaluation ___ Neuropsychological Evaluation

___ Physician Note ___ Presence/Participation in Treatment

___ Treatment Plan(s) ___ Intake Evaluation

Please Note- Medical records may contain sensitive information including, but not limited to: Alcohol, Drugs, Mental Health, HIV/AIDS, and Sexually Transmitted Diseases.

Purpose- The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Jodie Cohen PhD at 200 Delaware Ave, Delmar, NY 12054.. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

Form of Disclosure- Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure- I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Expiration- Unless sooner revoked, this authorization expires on the following date: _____, or as otherwise indicated:_____.

Signature of Client or Legal Guardian _____ Date _____

(If you are signing as a personal representative of an individual, please describe your authority to act for this individual, for example; power of attorney, healthcare surrogate, etc.)