Randi Most, Ph.D., ABN
Board Certified Neuropsychologist

Authorization to Release Protected Health Information

Patient Name:_____ DOB: _____

I hereby authorize Randi Most, Ph.D., at my request, to release and/or obtain the following protected health information from my clinical records:

Neuropsychological / Psychological Report ☐

Medical Records (including HIV& psychiatric) ☐

To/From: _____ _____

_____ _____

_____ _____

Check here if you do not give permission for email to be used to communicate with your medical/mental health providers ☐

This authorization shall remain in effect for one year. I make this consent voluntarily and understand that I may revoke this authorization, in writing, at any time. However, any revocation will not be effective to the extent that action has been 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 information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule

I understand that Dr. Most generally 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 acknowledge that I have read this authorization and fully understand its contents. I hereby release Dr. Most from any and all damages, claims and causes of action arising out of, or in connection with the release of this information.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian (if applicable) Date

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