Release of Information

This form serves as authorization for the use and disclosure of Protected Health Information (PHI) is only for the individual or agency named on this form.

You may request your records be sent to additional individual(s) or agencies by sending additional signed copies of this form located on our website (www.cahopewell.com/forms) to cahopewell@cahopewell.com or via fax at 682-312-9821.

Name: ________________________________ DOB: __________________

I, __________________, authorize Hopewell Neuropsychological Center, whose office is located at 601 University Drive STE 101 Fort Worth, TX 76107 to release/exchange by phone, fax, email, or mail my PHI with the following:

Name	Title (Doctor, Family, etc)	FAX #	Phone #

Reason for disclosure:

The PHI to be disclosed includes the following for the purposes of collaboration, insurance, continuing care/treatment, and legal:

- Diagnosis
- Progress notes
- Recommendations
- Psychological/Neuropsychological Report

Dates of records to be released:

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By signing below, I understand that my records contain information regarding my mental health. I give specific permission for this information to be released. I understand that my records are protected under State and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

This authorization expires on ______________ or 1 year from the date signed. I understand that I may revoke this authorization in writing at any time.

_________________________________ _______________________
Patient's Printed Name Date

_________________________________ _______________________
Patient 's Signature Date

_________________________________ _______________________
Parent/Guardian/Legal Representative Signature Date

For internal use (HNC employees) only:

Agency/Individual	Date	Time	Mode	Personnel