MIND MATTERS MEMPHIS
NEUROPSYCHOLOGY

Amanda M. Gould, Ph.D., HSP
Clinical Neuropsychologist

Authorization to Disclose Neuropsychology Records

The purpose of this document is to authorize the disclosure, without restrictions or qualifications unless noted in the Limitations (below), of information related to your neuropsychological or psychological evaluation(s), which is considered Protected Health Information as defined by the 1996 Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. parts 160 and 164).

This release is for **any and all written or verbally communicated information** about the undersigned, including personal/professional knowledge, neuropsychological or psychological testing results, psychological or medical records, and may include information regarding diagnosis and/or treatment for any or all of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including HIV or AIDS.

Your ability to receive treatment, payment, plan enrollment, or benefit eligibility normally does not depend on you signing this form. **You may refuse to sign this form.** However, we must have your signature to disclose your neuropsychological or psychological records to anyone you identify below.
Consequences of signing this form: Under federal privacy regulations, if you authorize the disclosure of your health information for a purpose beyond treatment, payment, or healthcare operations, your health information might later be re-disclosed and no longer protected by federal privacy regulations. This document indicates that you understand that any disclosure carries with it the potential for re-disclosure by the recipient, and that this is neither the fault of nor shall I hold responsible the sending party.

Revocation: You may revoke this Authorization in writing at any time, except to the extent it has already been relied on to make a disclosure. Any information released before such revocation and in reliance upon this authorization shall not constitute a breach of confidentiality. Your written revocation will become effective once it is received and processed. You may not have the right to revoke this Authorization to the extent it pertains to an insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to Amanda M. Gould, Ph.D., 5100 Poplar Avenue, Suite 322, Memphis, Tennessee, 38137.

Patient's full name:		
Date of birth (dd/mm/yyyy)		
Address:		
City:	State:	Zip:

5100 Poplar Ave. Suite 322
Memphis, TN 38137
mindmattersmemphis.com

Tel: 901-766-7500
Fax: 901-766-7550

Amanda M. Gould, Ph.D., HSP

Clinical Neuropsychologist

I authorize Mind Matters of Memphis to disclose to:

Recipient's name:		
Address:		
City:	State:	Zip:

With these limitations: _____

_____

_____

_____

Expiration: This Authorization expires on the date you specify below or one year from date signed, whichever is earlier. Once this Authorization expires, we will no longer be able to obtain your health information for the described purposes unless you sign a new Authorization form.
This Authorization expires (check one):

	In 12 months
	On the following date other than six months (dd/mm/yyyy)
	When the following event occurs:

_____ _____.

Signature of patient or personal representative — Printed name of patient or personal representative

_____ _____

Date — Relationship to patient (if personal representative)

*If personal representative, the patient is unable to sign because (check one):

	Minor
	Incompetent (please provide a copy of documentation and POA)
	Other

5100 Poplar Ave. Suite 322
Memphis, TN 38137
mindmattersmemphis.com

Tel: 901-766-7500
Fax: 901-766-7550