MIND MATTERS MEMPHIS

NEUROPSYCHOLOGY

Amanda M. Gould, Ph.D., HSP

Clinical Neuropsychologist

Authorization to Obtain Protected Health Information

The purpose of this Authorization is to permit us to obtain all or some of your health information, as you specify, for the purposes you describe. We are otherwise required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices. Your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit normally does not depend on your signing this form. **You may refuse to sign this form.** However, we must have your signature to obtain your protected health information from the organization you identified below.

The undersigned herby requests and authorizes the release without restrictions or qualifications unless stated of Protected Health Information pertaining to them as defined by the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rules (45 C.F.R. parts 160 and 164). Unless noted in the Limitations (below) this release is for any and all written or verbally communicated information about the undersigned, including personal/professional knowledge, treatment records, evaluation reports, psychological records, psychotherapy notes, medical records (including psychiatry records), alcohol and drug information, and personnel records. As such, I understand that Dr. Gould may obtain my personal health 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. The sender shall not be held liable for any breach of confidentiality occurring from record transmission.

Revocation: You may revoke this Authorization in writing at any time, except where it has already been used to obtain protected health information. 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 we receive and process it. 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:

I authorize ____ to release my health information by mail/fax to:

Recipient's name:	Amanda M. Gould, Ph.D.
Address:	5100 Poplar Ave, Suite 322, Memphis, TN, 38137
Phone:	901-766-7500
Fax:	901-766-7550

The following information from my medical record should be released:

	Complete medical record
	Progress notes

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