Southern Arizona Neuropsychology Associates

PERSONAL CONSENT FOR RELEASE OF INFORMATION

***This is for family or friends only, there is a separate release for physicians**.

Patient Name:___________________________________

Date of Birth:____________________________________

This is to authorize:

_______________________________ _______________________________

Name Relation to patient

____

Phone #

_______________________________ _______________________________

Name Relation to patient

____

Phone #

To receive and/or discuss the following information with Southern Arizona Neuropsychology Associates:
(*Please check each box that applies)*

- ☐ Neuropsychological/Psychological report, diagnosis, and/or suggestions
- ☐ Financial information/inquiries
- ☐ Other ____

If you do not wish to release any information to anyone, please check the box below.

- ☐ I do not authorize any other individual as a contact (beyond the HIPPA allowable).

This information is requested in case of an emergency, to allow psychological and/or financial access to an individual in addition to the patient (other than a physician), and/or in the event that our office is unable to speak with, or get in touch with the patient. By signing this document, the patient is releasing the right to disclosure of the specific information listed above. The patient is able to void this consent at any time by forwarding Southern Arizona Neuropsychology Assoc. a written request of nullification.

_____________________________________ _______________________

Client/Guardian Signature Date