Southern Arizona Neuropsychology Associates, LLC

403 W. Cool Dr. STE 107, Tucson, AZ 85704
Phone: (520) 329-8298 Fax: (520) 329-8311

RELEASE AUTHORIZATION / ASSIGNMENT OF BENEFITS

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Patient or Legal Representative Name

I understand that this evaluation may consist of formal testing of intellectual functioning. It may also include test of academic achievement, memory, language, speech, social/emotional functioning, and/or visual-motor coordination.

I understand that psychological / educational / medical information can only be released with my signed consent under the following conditions (and are explained further in the HIPAA Notice Form that will be available upon request):

- Such information may be sent to the referral source;
- Such information may be sent to assist in processing the insurance claim(s);
- Such information may be sent in response to a court order;
- Such information may be sent when the patient has threatened harm to him / herself or to others;
- Such information may be sent in response to suspected child or elder abuse;
- Such information may be sent in defense of psychological practice.

I authorize and request payment of benefits from my insurance company directly to Southern Arizona Neuropsychology Associates, L.L.C. I agree that this authorization shall cover all services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

I understand that I am responsible for paying any and all charges not paid by my insurance carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO IT'S TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE THE RIGHT TO REQUEST THE HIPAA NOTICE FORM DESCRIBED ABOVE.

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Signature of Patient or Legal Representative **Date**