

Southern Arizona Neuropsychology Associates, LLC

AUTHORIZATION TO RELEASE REPORT

Patient name

DOB

The final neuropsychological report will be released to your referring doctor:

Additionally, If you would like your neuropsychological report sent to any other medical provider(s) please list them below. Also, please list the phone and fax number for the medical provider, to ensure we are sending it to the correct office.

Medical Provider's Name

Phone #

Fax #

Medical Provider's Name

Phone #

Fax #

Patient signature

Date