Southern Arizona Neuropsychology Associates, LLC

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

CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

This is to authorize: Southern Arizona Neuropsychology Associates, L.L.C.
403 W. Cool Dr. STE 107, Tucson, Arizona 85704

To release:

_____ Complete medical records
_____ Psychiatric / Psychological records
_____ Raw test data
_____ Neuropsychological Evaluation Report
_____ Other _____

To: _____

_____

_____

I understand that this information will be used for the purposes of evaluation and /or ongoing treatment, and will not be disclosed without my prior written consent. I understand that this consent will expire 12 months after the date it was signed.

_____
Date

_____
Client or Guardian Signature