NEUROPSYCHOLOGY
& CONCUSSION MANAGEMENT
ASSOCIATES, LLC

This form, when completed and signed by you, authorizes Neuropsychology and Concussion Management Associates, LLC (NCMA) to release and/or receive (as indicated by you) protected information from your or your child's clinical record to and/or from the person/s or organizations you designate. You have a right to receive a copy of the completed authorization form upon request. You have the right to revoke this authorization at any time by sending written notification to NCMA. However, any such revocation would not be effective to the extent that we have already taken action in reliance on this authorization. Also, that revocation may be the basis for denial of insurance coverage or benefits. You do not have to sign this authorization in order to receive neuropsychological services unless the purpose of the service is to create health information for a third party. The information disclosed as a result of this authorization may be subject to redisclosure by the recipient, and depending on the recipient, may no longer be protected by the HIPAA Privacy Rule (e.g., attorney or school). You should be aware that unless you specify to refrain from certain disclosures, information disclosed from your record could include information related to substance use/abuse, mental health, or HIV status.

I authorize Neuropsychology and Concussion Management Associates, LLC (NCMA) to share my or my child's health information as indicated below:

- Exchange all necessary information for processing my insurance claim with: ________________________________

  Initial: _____________

- Release to – Exchange with – Receive from: ____

  Specifics: ____

  Initial: _____________

- Release to – Exchange with – Receive from: ____

  Specifics: ____

  Initial: _____________

- Release to – Exchange with – Receive from: ____

  Specifics: ____

  Initial: _____________

- Release to – Exchange with – Receive from: ____

  Specifics: ____

  Initial: _____________

This authorization shall remain in effect until revoked unless a time limit is indicated here:_______________
By signing below, I am indicating that I have completed this form, have read and understood all of the information on this form, and am giving my consent to the indicated disclosure of information.

____ ____________________

Signature of patient or parent/guardian Date

Printed name ______________________________ DOB: _______________

Name of patient if other than above: _______________________________________