The Neuropsychology Center
Alfonso Martinez, Ph.D., ABPP-CN
Licensed GA Psychologist PSY3117
Board Certified Clinical Neuropsychologist

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Authorization Form

This form, when completed and signed by you, authorizes me to **RELEASE/OBTAIN** protected information from your clinical record to / from the person you designate.

Name _____ Date of Birth _____

I authorize Alfonso Martinez, Ph.D. and/or his administrative and clinical staff
to **RELEASE:** ( ) Report of Psychological and/or Neuropsychological Evaluation
( ) Progress Notes – Specify:_____
( ) Clinical information via telephone – Specify: _____

to **OBTAIN:** ( ) History & Physical, Emergency Room, or Intake Evaluation Report(s)
( ) Office/Hospital Notes/Progress Notes – Specify: _____
( ) Laboratory Reports – Specify: _____
( ) EEG, MRI, fMRI, PET, MRA, and CT scan reports of head or spine
( ) Clinical Information via Telephone – Specify: _____
( ) Academic Records, including Grade reports, Achievement and Scholastic Aptitude Test results, and Behavioral records for period: _____

This information should only be **RELEASED** to / **OBTAINED** from: _____

Address: _____ Phone: _____ Fax: _____

I am requesting Dr. Martinez **RELEASE** / **OBTAIN** this information for the purpose of:

( ) Psychological/Neuropsychological Evaluation ( ) Treatment coordination and/or planning ( ) Disability Determination ( ) Other _____

This authorization shall remain in effect no longer than 365 days or until _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____ _____
Patient Representative or Guardian (relationship to patient) Date

_____ _____
Witness Date