The Neuropsychology Center
Peggy McBrayer, ACSW, LCSW, LPC. & Tom McBrayer, LPC
Individual & Couples Therapists

6000 Shakerag Hill, Suite 216
Peachtree City, GA 30269

Telephone: (770) 632-1088
Facsimile: (770) 632-2088

HIPAA Privacy 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. (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I, _____ _____/_____/_____ authorize
Patients Name **Date of Birth**

The Neuropsychology Center administrative and clinical staff to use, disclose and/or obtain protected health information described below to the following persons, ie: doctors and/or family members.

Name: _____Phone: _____

Name: _____Phone: _____

2. Effective Period

This authorization for release of information covers the period of healthcare from:

( ) ALL past, present, and future periods **OR** from _____ to _____. **(Date Range)**

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

3. Extent of Authorization: I am requesting The Neuropsychology Center **RELEASE / OBTAIN** this information for the purpose of:

( ) Report of Psychotherapy and Psychological Evaluation, Progress Notes
( ) Clinical information via telephone – Specify: _____
( ) History & Physical, Emergency Room, or Intake Evaluation Report and Office/Hospital Notes/Progress Notes
( ) EEG, MRI, fMRI, PET, MRA, and CT scan reports of head or spine and Laboratory Reports
( ) Telephone – Messages to confirm or make appointments

4. Use of Information

This medical information may be used by the person I authorize to receive this information for Psychological, Psychotherapy Evaluation/Consultation, Treatment coordination and planning, Billing or Claims payment, Disability determination or other purposes as I may direct.

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 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