Neuropsychology

5930 E Pima Street Suite 138, Tucson AZ 85712 . phone 520-441-4006 . fax 855-249-5320

Authorization to Request/Release Information

I, _____, hereby authorize

(Individual or Entity): _____

Address: _____

Phone/Fax: _____

To release information concerning _____, DOB_____,
(Client) *(Client's DOB)*

to Sarah B. Burger, Ph.D. of A-Z Neuropsychology, LLC
(address and contact information contained in the header)

Nature and Purpose of Release:

This disclosure is for the purpose of: _____

Items and information to be released include:_____

_____

Limitations of Release:
I wish to exclude the release of information pertaining to (*None, if left blank*):

_____

Conditions of Release:

- I understand that I may refuse to sign this authorization and that my refusal will not affect my eligibility to obtain services from A-Z Neuropsychology, LLC. _____ (initial)
- I understand that my signature authorizes the release of this information only from the above-named persons or agencies, and not from Dr. Burger to the above-named person or agency. Any information released to Dr. Burger will not be made available to others who request it secondarily and the information will not be re-released to any other person or agency. _____ (initial)
- I understand that I may revoke this authorization at any time by giving written notice to either the above-named entity or to A-Z Neuropsychology, LLC, after which no further information will be requested/ released. I understand that this release is in effect for 365 days (1 year) unless rescinded in this manner. _____ (initial)

_____ _____
Client Signature Date

_____ _____
Parent/Guardian or Authorized Surrogate Signature Date

_____ _____
Witness Signature Date