



PROFESSIONAL CONSULTING • CLINICAL ASSESSMENT • EDUCATIONAL MAPPING

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I hereby authorize that such health information regarding the above-named person be forwarded:

FROM: Dirksen Center for Neuropsychology, Ltd. 855 East Golf Road, Ste 2139, Arlington Heights, IL 60005

(CHECK ALL THAT APPLY)

- checkbox Courtney L. Dirksen, Ph.D. checkbox Lisa Sorensen checkbox Lauren Laake, Ph.D. checkbox Karen Burcham, Ph.D. checkbox Tria Murphy, Ph.D.

FAX: 847-701-3275 PHONE: 847-357-9158

TO: _____
Person/Institution
Address
City State Zip
Phone Fax

Purpose of need for information: _____

Disclosure will include the following verbal or written information (circle all that apply):

- Full neuropsychology report, Psychological Assessment, History and Physical, Neuropsychology report summary and recommendations, School Information, Neuropsychology raw data (psychologist only), Therapy/treatment notes and plans, Inpatient Neuropsychology Consult, Summary of treatment/therapy, Billing/Insurance information, Other: _____

Records for the period (dates) from _____ to _____

If I do not sign this Authorization, the institution named above will not release my health information. I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent if the action has already been taken to release this information. This Authorization shall remain valid unless revoked. I have the right to inspect the copy of the health information to be released. The above named person will not refuse to treat me based on whether I agree to allow this information to be used and disclosed to others.

Patient Signature _____ Date _____

OR

Signature of Parent/Legal Guardian/Legal Representative _____ Date _____

Relationship to the Patient _____

Witness _____ Date _____

REDISCLASURE: Notice is hereby given to the patient or legal representative signing this Authorization that the Dirksen Center for Neuropsychology cannot guarantee that the recipient receiving the request will not redisclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.