



# DIRKSEN CENTER FOR NEUROBEHAVIORAL HEALTH

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:

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

**(CHECK ALL THAT APPLY)**

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

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

**FROM:** \_\_\_\_\_

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 will not redisclose any or all of it to others. Law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.