Neuropsychology Associates of North Texas, P.A.

Authorization to Release Neuropsychological or Psychological Reports and/or results.

I am completing this form to allow the use and disclosure of protected health information, specifically, neuropsychological or psychological reports generated from the evaluation (testing) with Dr. Michelle Bengtson. This release can be faxed to 817-416-2731 or emailed to pcc@texnant.com. ***PLEASE INCLUDE A COPY OF A STATE ISSUED ID.*** *We cannot release reports without a copy of a state ID.*

Patient Name: _____ ***DOB:*** _____

Address: _____

Phone: _____ ***Parent/guardian (If applicable)***_____

I authorize Dr. Michelle Bengtson Neuroopsychology Associates of North Texas to disclose a copy of the neuropsychological or psychological report to:

1. ***Family Member/ Doctor/Therapist:*** _____ ***Patient Initial*** _____

Address: _____ **City:** _____

Phone: _____ **Fax:** _____ **Date Sent:** _____ **By Whom:** _____

2. ***Family Member/ Doctor/Therapist:*** _____ ***Patient Initial*** _____

Address: _____ **City:** _____

Phone: _____ **Fax:** _____ **Date Sent:** _____ **By Whom:** _____

3. ***Family Member/ Doctor/Therapist:*** _____ ***Patient Initial*** _____

Address: _____ **City:** _____

Phone: _____ **Fax:** _____ **Date Sent:** _____ **By Whom:** _____

_____ _____

Patient or Guardian Signature ***Date signed***

_____ _____

Witness ***Date signed***