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 an evaluation (testing) with Dr. Michelle Bengtson. Please complete this form and mail it with a copy of of a state issued ID and a check for $25 to our office at

Neuropsychology Associates of North Texas
ATTN: RECORDS
1340 N White Chapel Blvd, Suite 130
Southlake, TX 76092

For a faster response, please include a secure email address and mark that the report be emailed. Parent or guardian signature is not acceptable for a patient age 18+.

Patient Name: _____ DOB: _____

Address: _____

Phone: _____ Parent/guardian (If applicable)_____

I authorize Dr. Michelle Bengtson Neuropsychology 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: _____

☐ **Please email this report to: (email address) _____**

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

Address: _____ City: _____

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

_____ _____

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

_____

Printed Name