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 made out to DR. MICHELLE BENGTSON** to our NEW ADDRESS at:*

Dr. Michelle Bengtson
ATTN: RECORDS
2140 E. Southlake Blvd., #L-658
Southlake, Texas 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+. If you have a medical power of attorney for a patient, please also send a copy of that.

Patient Name: ____ ***DOB:*** ____________________

Address: ____

Phone: _____________________________ ***Parent/guardian (If applicable)***_______________________

I authorize Dr. Michelle Bengtson 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***

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Printed Name