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
1361 W. Wade Hampton BLVD
Suite F-298
Greer, SC 29650

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***

_____

Printed Name