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AUTHORIZATION TO OBTAIN / RELEASE PATIENT INFORMATION

Patient Name: ______________________________________ Patient DOB: _________________

1. I authorize Dr. Gould and/or his administrative staff to obtain or disclose the following information:

☐ release ☐ obtain ☐ exchange	Neuropsychological Evaluation
☐ release ☐ obtain ☐ exchange	Verbal Case consultation
☐ release ☐ obtain ☐ exchange	Educational Material
☐ release ☐ obtain ☐ exchange	Consultation Reports
☐ release ☐ obtain ☐ exchange	Neuroimaging (EEG, CT, MRI)/Lab Reports
☐ release ☐ obtain ☐ exchange	Office Visit Notes
☐ release ☐ obtain ☐ exchange	Psychiatric Admission/Discharge Paperwork
☐ release ☐ obtain ☐ exchange	Other: _____________________________

2. Information is to be released for the following:

   ☐ Evaluation / Continuing Treatment

   ☐ Coordinating Care

   ☐ Other: ____________________________________

3. This authorization shall remain in effect:

   ☐ Until Revoked ☐ 6 months ☐ 1 year

4. Information will be released to or obtained from: ____

   ____

   ____

5. Signature of Patient/Parent/Guardian: __________________________________ Date: ____________

   Signature of Witness: ____