glassman
NEUROPSYCHOLOGY
ASSOCIATES LLC

Release of Information
Authorization for Use/Disclosure of Health Information

Patient Name: Date of Birth:

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize the listed person(s), organization(s) and/or health care provider to receive and use my treatment records and/or health information during the term of this Authorization to the recipient(s) that I have identified below.

Disclosure: I authorize Glassman Neuropsychology Associates LLC 2448 S 102nd St #270, Milwaukee, WI 53227, or their designee, to release/disclose my treatment records and/or health care information.

Recipient: I authorize my treatment records and/or health care information to be released to the following recipient(s):

Name: _____

Address: _____

Date(s) of Assessment or Treatment: _____

Purpose: I authorize the release of my health information for the following specific purpose Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:

- ☐ Legal
- ☐ Personal Record
- ☐ Continuity of Care
- ☐ Other: _____.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All of my health/treatment information from the assessment or treatment that the provider rendered and has in his or her possession.

☐ Only the following records or types of health information:

_____

_____

_____

Term: I understand that this Authorization will remain in effect until the request is fulfilled.

Right to revoke: I understand that signing this form is voluntary. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Glassman Neuropsychology Associates LLC. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not have any effect on any action taken by Glassman Neuropsychology Associates LLC in reliance on this Authorization before it received my written notice of revocation. If this authorization was obtained as a condition for providing treatment or evaluation, such as in the case of court ordered evaluations, then a revocation will not be effective.

Non-health care providers: I understand that organization(s) that are not health care providers or affiliated organizations are not subject to federal privacy standards. As such, my health information disclosed pursuant to this authorization may no longer be protected by federal privacy standards if the recipient(s) are not bound by federal privacy standards. Such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

I understand that Glassman Neuropsychology Associates, LLC, charges $15.00 for records and may receive other direct or indirect remuneration in connection with the use and/or disclosure of my health information. Such remuneration is governed by reasonable fees for copying records to release information.

Questions: I may contact Glassman Neuropsychology Associates LLC for answers to my questions about the privacy of my health information bu sending a letter to 1760 Cedar Ridge Drive, Slinger, WI 53086 or by telephone at (414) 614-6392.

_____	_____	_____
Signature	Date	Signature of Witness

If individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness