NEUROBEHAVIORAL INSTITUTE OF AUSTIN

NEUROPSYCHOLOGY, CLINICAL PSYCHOLOGY, COUNSELING, ASSESSMENTS, EDUCATIONAL CONSULTING

Scott Hammel, Ph.D. Lisa Hammel, M.Ed. Carney Soderberg, Psy.D.
Lauren Farwell, Psy.D. Stephen Roeckeman, Psy.D.
Zina Eluri, Ph.D. Laura Marques, Ph.D. Lindsay Heath, Psy.D.

Authorization for Use or Disclosure of Confidential Information

Patient name_____Patient DOB _____

I hereby authorize (check all that apply):

- ☐ Scott Hammel, Ph.D.
- ☐ Lisa Hammel, M.Ed.
- ☐ Carney Soderberg, Psy.D.
- ☐ Lauren Farwell, Psy.D.
- ☐ Zina Eluri, Ph.D.
- ☐ Stephen Roeckeman, Psy.D.
- ☐ Laura Marques, Ph.D.
- ☐ Lindsay Heath, Ph.D.
- ☐ Alexandra Elliot, Ph.D.

To (check only one):

- ☐ Release to
- ☐ Obtain from
- ☐ Mutually Exchange

Name of person / facility_____

Relationship to patient (Ex: Therapist, Parent, etc)_____

Address_____

Phone_____Fax_____*or* E-mail_____

Check the following:

- ☐ Complete Record
- ☐ Billing information (account information, payment, and scheduling appointments)
- ☐ Psychological/Neuropsychological Report
- ☐ Progress Notes
- ☐ Exchange information orally about my medical record
- ☐ Behavior Rating Scales
- ☐ Other (*specify*) _____

Purpose of disclosure:

- ☐ Medical coordination of care
- ☐ Insurance / Billing
- ☐ Attorney / Legal
- ☐ Educational

This authorization is valid for:

- ☐ One time only
- ☐ One year from today

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged.

Patient or responsible party signature_____Date _____

Please return this form and/or requested information to fax number (512) 329-0087.