NEUROBEHAVIORAL INSTITUTE OF AUSTIN

NEUROPSYCHOLOGY, CLINICAL PSYCHOLOGY, COUNSELING, ASSESSMENTS, EDUCATIONAL CONSULTING

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.
- ☐ Laura Marques, Ph.D.
- ☐ Lindsay Heath, Ph.D.
- ☐ Stephen Roeckeman, PsyD.
- ☐ Cristina Casstevens, Ph.D.
- ☐ Zina Eluri, Ph.D.
- ☐ Amber Moreland, Ph.D, Postdoctoral Resident *(supervised by Scott Hammel, Ph.D)*
- ☐ Evangelina Barnard, Psy.D., Postdoctoral Resident *(supervised by Scott Hammel, 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.

3660 Stoneridge Road, Building F-101 · Austin, TX 78746 · Phone: 512-329-8222
Fax: 512-329-0087 · Info@NBAustin.com · www.neurobehavioralaustin.com