NEUROBEHAVIORAL INSTITUTE OF AUSTIN

NEUROPSYCHOLOGY, CLINICAL PSYCHOLOGY, COUNSELING, ASSESSMENTS, EDUCATIONAL CONSULTING

Scott Hammel, Ph.D. • Lisa Hammel, M.Ed. • Carney Soderberg, Psy.D.
Bryn Schiele Moore, Ph.D. • Stephen Roeckeman, Psy.D.
Lauren Farwell, Psy.D. • Sharon Arffa, Ph.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.
Bryn Schiele Moore, Ph.D.	Stephen Roeckeman, Psy.D.	
Lauren Farwell, Psy.D.	Sharon Arffa, 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
Educational

This authorization is valid for:

One time only
Not more than 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.