Ellen Braaten, PhD & Associates

Licensed Psychologists
Neuropsychological Assessment and Consulting Services

127 Main Street ♦ Charlestown, MA 02129

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Patient Address:_____

Telephone Contact:_____

I, _____ do hereby authorize **Ellen Braaten, PhD & Associates** to:
(Patient or Legal Guardian)

❒**YES** ❒**NO** Release protected health information (including neuropsychological evaluation results) to those individuals/organizations listed below

❒**YES** ❒**NO** Obtain protected health information (including medical, neuropsychological, psychiatric, or educational records) from those individuals/organizations listed below

1.	**2.**	**3.**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that:

- I may withdraw my authorization at any time by written request
- I may refuse to sign this authorization
- This authorization will expire in six months (unless otherwise specified)

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information to those persons or agencies listed above.

Patient's Signature: _____ Date:_____

Or, when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Parent/Guardian's Signature:_____ Date:_____

Print Name:_____ Relationship to patient_____