PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

MICHELLE LURIE, Psy.D., ABPdN

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Authorization Form

This form when completed and signed by you, authorizes me to release and obtain protected information from your clinical record to the person you designate.

_____I authorize Michelle Lurie, Psy.D.; ABPdN to release and exchange pertinent verbal and/or written information to the party or parties named below for the purpose of clinical evaluation and/or treatment.

_____I authorize the party or parties listed below to release pertinent verbal and/or written information concerning the physical/emotional health from my clinical records to Michelle Lurie, Psy.D.; ABPdN. This does not include the exchange of information.

_____	_____
Name	Telephone Number
_____	_____
Name	Telephone Number
_____	_____
Name	Telephone Number
_____	_____
Name	Telephone Number

This authorization shall remain in effect until: / /

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

_____	_____
Name of Patient	Date of Birth
_____	_____
Signature of Patient /Guardian	Date