DIRKSEN CENTER

PROFESSIONAL CONSULTING • CLINICAL ASSESSMENT • EDUCATIONAL MAPPING

Patient Name: _____ **Date of Birth**: _____

Address: _____ **Phone**: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I hereby authorize that such health information regarding the above-named person be forwarded:

FROM: Dirksen Center for Neuropsychology, Ltd. 855 East Golf Road, Ste 2139, Arlington Heights, IL 60005
FAX: 847-701-3275 PHONE: 847-357-9158

(CHECK ALL THAT APPLY)

☐ Courtney L. Dirksen, Ph.D.	☐ Lisa Sorensen, Ph.D.	☐ Karen Burcham, Ph.D.
☐ Tria Murphy, Ph.D.	☐ Lauren Laake, Ph.D.	☐ Susan Klostermann, Ph.D.

TO: _____
Person/Institution

_____
Address

_____
City State Zip

_____
Phone Fax

Purpose of need for information: _____

Disclosure will include the following verbal or written information **(circle all that apply)**:

►Full neuropsychology report	►Neuropsychology report summary and recommendations	►Therapy/treatment notes and plans
►Psychological Assessment	►School Information	►Inpatient Neuropsychology Consult
►History and Physical	►Neuropsychology raw data (psychologist only)	►Summary of treatment/therapy
		►Billing/Insurance information

►Other: _____

Records for the period (dates) from _____ to _____

If I do not sign this Authorization, the institution named above will not release my health information. I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent if the action has already been taken to release this information. This Authorization shall remain valid unless revoked. I have the right to inspect the copy of the health information to be released. The above named person will not refuse to treat me based on whether I agree to allow this information to be used and disclosed to others.

_____ _____
Patient Signature Date

OR

_____ _____
Signature of Parent/Legal Guardian/Legal Representative Date

_____
Relationship to the Patient

_____ _____
Witness (required) anyone 18 years or older Date

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that the Dirksen Center for Neuropsychology cannot guarantee that the recipient receiving the request will not redisclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.