Cognitive Health *Solutions* LLC

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Authorization to Release Healthcare and/or Educational Information

Patient Name:		Date of Birth:	
I hereby authorize Cognitive Health *Solutions*, LLC to:	☐ Release to	☐ Obtain from	
Person or Facility:			
Person or Facility Phone #:		Person or Facility Fax #:	
Person or Facility Address:			
☐	**All available information and records may be released to and received from the individual/facility listed above.**		
☐	Verbal Communication	☐	Contact, scheduling, & demographic information
☐	Education goals, planning, records, and testing	☐	All information necessary for payment/insurance
☐	Legal history/involvement with court system	☐	Professional observations, opinions, and impressions
☐	Laboratory tests with imaging results (ex. X-ray MRI)	☐	Medication History and evaluation(s)
☐	Psychological/Psychiatric testing, evaluation, diagnosis, treatment, and recommendation information		
☐	Other (specify):		
For the purpose of:	☐ Continuity of Care ☐ Treatment Planning ☐ Discharge Planning ☐ Other:		

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

I understand that the information in my health care record may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

I understand that services are not conditioned upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule. This consent will expire: One Year .

_____ _____
Signature of Patient (if 18+ years old) Date

_____ _____
Signature of Mother/Legal Guardian #1 (if patient is under 14 years old) Date
***If joint legal custody exists, both parents/guardians must sign**

_____ _____
Signature of Father/Legal Guardian #2 (if patient is under 14 years old) Date

Signature of Witness (if 18+ years old)

To Recipient: This information has been disclosed to you for your records alone. Confidentiality is protected by Federal Law. Federal Regulation 42FR, part 2, prohibits you from making any further disclosure of this information, in writing or otherwise, without the specific written consent of the person whom it pertains or as provided by such regulations.