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RELEASE OF INFORMATION

Client Name: _____ Date of Birth: ____/____/____

I hereby authorize Rocky Mountain Neuropsychology Consultants, LLC to communicate regarding the following protected information from my records (those checked):

To be released by RMNC **to:** (name) _____
[ ] Psychological/Neuropsychological Evaluation Results (institution) _____
[ ] Treatment/Diagnostic Records (street)_____
[ ] Summary of Treatment (city/state/zip)_____
[ ] Other (specify): _____ (phone) **( )** _____-_____

To be released to RMNC **from:**(name)_____
[ ] Psychological/Neuropsychological Evaluation Results (institution) _____
[ ] Psychological/Neuropsychological Evaluation Raw Data (street)_____
[ ] Psychiatric/Psychological Treatment/Diagnostic Records (city/state/zip)_____
[ ] Medical Records (phone) **( )** _____-_____
[ ] Summary of Treatment
[ ] Academic History Records
[ ] IEP Evaluations
[ ] Occupational History Records
[ ] Legal Documents/Records
[ ] Other (specify): _____

The purpose of this exchange of information is to:
[ ] Conduct a formal evaluation and/or consultation
[ ] Clinical treatment

The information exchanged should reflect material collected:
[ ] In the last six months
[ ] In the last year
[ ] In the last five years
[ ] Since first contact with the client

This authorization form is valid for:
[ ] Three months
[ ] Six months
[ ] Twelve months

I may revoke my consent for release of this information at any time except to the extent that information was released prior to the revocation of consent.

_____ _____
Client Signature *Date*

_____ _____
Parent/Guardian/Conservator Signature *Date*