Neurobehavior North, Inc.

RELEASE OF INFORMATION

TO ENSURE CONTINUITY OF CARE, WE NEED TO PROVIDE REPORTS OR OTHER INFORMATION TO YOUR REFERRING OR OTHER HEALTH CARE PROVIDERS

I, _____, give Neurobehavior North, Inc. (Dr. Dustin Logan) permission to release and/or exchange the following protected information from my clinical record about my evaluation and/or treatment:

_____ Neuropsychological Evaluations
_____ Psychological Evaluations
_____ Verbal Communications (Personal and Telephonic)
_____ Billing Information
_____ General Summaries
_____ Any and all of the above

This information should be sent to (name, address, and phone number):

1) _____

_____

2) _____

_____

3) _____

_____

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information, as well as specifying the situations under which exceptions to confidentiality may occur. This authorization to release information from my records and for verbal communications is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that I may revoke this consent (in writing) at any time up to the extent that action based on this release has been taken by sending a written request to our office. However, your revocation will not be effective to the extent that Neurobehavior North, Inc. has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim. I understand that AVCS generally may not condition service provision upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and may no longer protected by the HIPAA Privacy Rule. This consent will expire automatically one year from the date on which it is signed below (***). Earlier termination of this Release can be specified in writing to Neurobehavior North, Inc.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. A photocopy of this consent shall be considered as effective and valid as the original.

_____ _____
Signature Patient Date of Birth

_____ _____
Witness (***) Today's Date