REQUEST FOR INFORMATION

TO PROVIDE THE BEST TREATMENT FOR YOU, WE MAY NEED TO REVIEW INFORMATION FROM YOUR OTHER HEALTH CARE PROVIDERS

I, ______________________________________, request that the following health information be released on my behalf:
(PRINT FULL NAME)

From:____

____

To: Neurobehavior North, Inc.
Attention: Dr. Dustin Logan, Ph.D., ABPP
PO Box 3034
Palmer, AK 99645

_____ History & Physical
_____Neurological exam findings
_____Neuroradiognostic exam findings (neuroimaging, EEG, etc) / images
_____ Psychological Testing
_____ Neuropsychological Testing
_____ Discharge Summaries
_____ Other: ____

_____ Reports of CT/MRI/EEG
_____ Psychotherapy Summaries
_____ Blood Laboratory Findings
_____ Work Performance Evaluations
_____ Military Records
_____ School Records

The purpose for the release of this data shall be for professional services only. This authorization and request to obtain information from my records 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 except to the extent that action based on this release has been taken. This consent will expire automatically one year from the date on which it is signed below. Earlier revocation must be received in writing.

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.

Signature____ Patient's Date of Birth_____________________

Witness ____ Today's Date_______________________________

If you are a legal representative of the patient (parent/legal guardian), please indicate your authority to sign and act for the patient.