JAMES W. PIER, PH.D.
CLINICAL NEUROPSYCHOLOGIST

Authorization for Release of Information

I, the undersigned patient or legal representative(s), hereby authorize the use and disclosure of health information including medical records, neuropsychological/psychological evaluation reports.

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

Fill out for Dr. Pier to Disclose Information

I authorize James W. Pier, Ph.D. to disclose health information to:

Name: _____

Address:_____
_____
_____

Telephone #: _____
Fax # : _____

Fill out for Dr. Pier to Obtain Information

I authorize _____

_____

To disclose health information to:
James W. Pier, Ph.D.
609 West Johnson Avenue, Suite 106
Cheshire, CT 06410
Ph. 203-272-6006 FAX 203-272-1547

The purpose of this release is to:

Send Report:_____ Consult/Coordinate Care:_____ Other (please specify):_____
_____

I understand that I have the right to revoke or change this consent at any time, but that any revocation or changes will have no effect on previously released information. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may be no longer protected by federal; privacy regulations. This release is good for two years from the date signed.

_____ _____
Patient Signature Date

_____
Print Name

_____ _____
Parent/Guardian Signature Date

_____
Print Name