PEACHTREE NEUROPSYCHOLOGICAL ASSOCIATES, P.C.

Thomas G. Burns, Psy.D., ABPP Board Certified in Clinical & Neuropsychology

AUTHORIZATION FOR RELEASE OF MEDICAL, EDUCATION, AND/OR PSYCHOLOGICAL INFORMATION

Please list the name, address, and/or phone number of the individuals to where you would like copies of the final Neuropsychological Report sent. The release of information provided below will serve as your permission to send the report and consult with the individuals that are listed:

I, _____ representing, _____ ___/____/___, authorize
(Patient or Personal Representative) (Patient) (Patient's Date of Birth)

Dr. Thomas G. Burns and Peachtree Neuropsychological Associates, P.C. to release and obtain information from the following individuals:

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

The purpose for this disclosure is for Neuropsychological Assessment and Follow-up.

I have read, or had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this consent at any time, except to the extent that action has already been taken in accord with this consent. In any event, this consent will expire (unless expressly revoked earlier) thirty-six (36) months from the date signed by the patient or legally authorize agent. Additionally, I have been given the opportunity to review the Patient Privacy Notice required by HIPAA and may request a copy if I so desire.

_____ ____ / ____ / ____
(Signature of Patient or Personal Representative) (Date)

_____
(Description of Personal Representative's Authority)

_____ ____ / ____ / ____
(Witness) (Date)

**** Note: Please provide copies of any previous assessments, medical reports, and/or academic records that would be helpful in completing your evaluation.

Thank you for your cooperation,
Dr. Burns

p.770-220-0887

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