Mt. Diablo Memory Center Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Dr. Eric J. Freitag and Dr. Gina Murrell and the staff of the Mt. Diablo Memory Center to release the following protected health information (PHI) from my clinical record:

- o Neuropsychological Report
- o Post-concussion Consultation Report
- o Other: (Please specify below)

_____

I authorize information regarding my care to be released to the following individuals:

- o Primary Care Doctor: _____
- o Referring Provider (if different): _____
- o Spouse: _____
- o Other family members:_____

  _____

- o Other professionals participating in my care: _____

  _____

- o I request that a copy of the report be sent to me (the patient).

I would like to put the following limitations on this release:

_____

_____

This authorization shall remain in effect until:

- o The termination of treatment
- o Expiration date determined by the patient _____

[continued on back side]

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation to the Mt. Diablo Memory Center office address. Notice of revocation will not be effective until received by the Mt. Diablo Memory Center.

I understand that the purpose of this release is to assist with facilitating communication between professional service providers, agencies or other individuals named in this document. I understand the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these risks.

I 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 be protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

_____

Signature of patient representative (if applicable)

If a patient representative signs this authorization form, a description of such representative's authority to act for the patient must be provided.