Carmel Neuropsychology Services, P.C.
755 West Carmel Drive, Suite 205
Carmel, IN 46032
317-610-0166 (fax) 317-571-0088 CNS@CarmelNeuro.com www.CarmelNeuro.com

AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE CAREFULLY READ AND COMPLETE. SIGNATURES MUST BE DIGITALLY SIGNED IN A PDF READER OR IN WRITING. TYPED SIGNATURES OR INITIALS WILL NOT BE ACCEPTED. To complete this fillable form, you will need to download the document and open in a free PDF reader (not website browser).

This form authorizes Carmel Neuropsychology Services, P.C. to release and/or share protected information from your clinical record to the person you designate below:

Name of person to **receive** records: _____

Relationship to Patient: _____

Fax Number: _____ Email: _____

This authorization will result in a **one-time transfer** of records to the individual noted above once this fully completed form has been received along with your payment. A separate release and payment will be required for each release.

I understand that CNS, P.C. will maintain records for the standard 7 years as per licensing and practice standards.

I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and may no long be protected by the HIPAA Privacy Rule.

I authorize payment of $35 for this authorization of a one-time transfer by signing this form.

Payment
Name on Card: _____
Card Number: _____
Expiration MM/YY: _____
CVV: _____
Zip associated to the card: _____

_____ _____
Patient Name Patient's Date of Birth

_____ _____
Patient, Parent, Guardian, or POA Signature (as applicable) Date

PLEASE RETURN THIS COMPLETED PDF FORM (AND ALL OTHER FORMS PER YOUR INSTRUCTIONS PROVIDED IN THIS DOCUMENT) BY EMAIL, FAX, OR BY MAIL. IF PAYING BY CASH, CHECK, OR MONEY ORDER, YOU MUST RETURN THIS DOCUMENT BY MAIL WITH YOUR PAYMENT.

PLEASE NOTE THAT **PDF FORMAT** IS THE ONLY FILE FORMAT WE CAN ACCEPT DIGITALLY.

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