NeuroDevelopment Center
245 Waterman Street, Suite 200, Providence RI 02906
575 Mount Auburn Street, Suite B-102, Cambridge MA 02138

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL HEALTHCARE INFORMATION

Patient:_____ Date of Birth:_____

Street:_____ City:_____

State:_____ Zip Code:_____ Phone number:_____

This Authorization permits the NeuroDevelopment Center, Inc staff to discuss and/or disclose protected health information concerning the patient named above to the Designated Party named below. This Authorization also permits the Designated Party named below to discuss and/or disclose protected health information concerning the patient named above to the NeuroDevelopment Center, Inc.

Designated Party:_____

Street:_____City:_____

State:_____ Zip Code:_____ Phone number:_____

This information will be used or disclosed for the following purposes:

☐ At the request of the individual

☐Other:_____

Please read below carefully before signing this document:

1. Please note all Clinicians at the NeuroDevelopment Center reserve the right to omit raw testing materials and observation notes from medical records.
2. I understand I will be charged a $50 medical record processing fee for photocopied records released to designated parties.
3. I understand and authorize the release of any records regarding drug, alcohol, or mental health treatment to the designated party listed above.
4. I understand that my treatment will not be affected if I do not sign this Authorization.
5. I understand that I may revoke this Authorization at any time by notifying the NeuroDevelopment Center, Inc **in writing**; however, if I do revoke the Authorization, it will not have any influence on any actions taken in reliance upon this Authorization by the NeuroDevelopment Center, Inc. prior to the receipt of the revocation.
6. I understand that this Authorization is effective for the lifetime of the patient, unless revoked (see #5).

Please note in order for our office to complete this request in a timely manner please be sure all information is completely and accurately filled out.

_____ _____

Signature of patient or patient's Authorized Representative **Date**