Sandra Bowker and Associates, PLC

Neuropsychology and Counseling Psychology

Authorization to Release Confidential Records and Information

Full Name of Patient____

Date of Birth____________________

I authorize the representatives and/or clinical staff of Sandra Bowker and Associates to release and/or receive medical, psychological and/or neuropsychological information regarding myself or the individual named above from/to the following:

(please list all providers and specialty involved in your care)

____ (Primary Care)

____ (other)

____ (other)

____ (other)

- I understand that, at any time, this authorization may be revoked, when the office receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

____________________ Date

____ Signature of Individual or Representative

____ Authority or Relationship to Individual, if Representative

Unless otherwise stated, this authorization will expire six years from the date of this authorization.