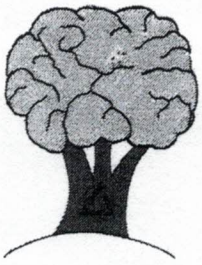

New Beginnings Neuropsychology, PLLC
Crystal Beadle, Ph.D.
4645 Avon Ln #160A
Frisco, TX 75033
Tel: 469-731-5440
Fax: 469-731-5537

AUTHORIZATION FORM TO RELEASE PROTECTED MEDICAL INFORMATION

(Allows US to SEND YOUR RECORDS to OTHERS)

Dear Patient: ***This form, when completed and signed by you, authorizes Dr. Beadle to release protected information from your clinical record to the entities you designate. Please read this form thoroughly and call our office if you need more explanation about the terms of this form.***

I authorize my psychologist, Crystal Beadle, Ph.D. to release my (check all that apply):

- ❑ Clinical Information to specified individuals via oral communication
- ❑ Neuropsychological evaluation report
- ❑ Treatment records (excluding psychologist's process notes)
- ❑ Raw neuropsychological test data (to another qualified mental health professional only)
- ❑ Billing and insurance records
- ❑ Medical records generated by other professionals I have seen
- ❑ Other records in my chart (specify these below):

_____

This information should only be released to the following people/organizations: (*Please provide full information if possible*)

1. Name:_____

   Address:_____

   Phone:_____ Fax:_____

Your Initials	

_____ _____

Child's Name Date of Birth

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2. Name:_____

   Address:_____

   Phone:_____ Fax:_____

Your Initials	

3. Name:_____

   Address:_____

   Phone:_____ Fax:_____

Your Initials	

I am requesting my psychologist to release this information for the following reasons: *("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)*

_____

This authorization shall remain in effect for 90 days or until (*specify date or specific future event*)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective for Protected Health Information that I have already released in response to this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. However, I understand that if I do not permit my psychologist to release the minimum information necessary to obtain payment from my insurance company or other third party, I will pay for any services at the time they are rendered.

I understand that information used or disclosed by Dr. Beadle based on this authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____ _____

Signature of Patient or Representative Date Relationship to Patient