VILLAR NEUROPSYCHOLOGY, LLC
AUTHORIZATION TO OBTAIN AND/OR RELEASE
PROTECTED HEALTH INFORMATION

By signing this Authorization, I permit the use and/or disclosure of my protected health information (medical record) for the limited purpose(s) and in the limited manner described on this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name:_____ Date of Birth:_____

I authorize Rebecca C. Villar, PsyD; Kristin Mickel, PsyD; Sarah Garcia, PhD, and/or the administrative staff of Villar Neuropsychology to:

_____Disclose to and/or _____ Obtain from:_____
(Name and Location of Facility or Person)

the following information contained in my medical record regarding assessments and/or treatment:

_____ Complete Medical Record
_____ Therapy Records
_____ Evaluation/Consultation Reports
_____ Verbal Exchanges of Information
_____ All Diagnostic Test Results
_____ Other

I understand that this Authorization extends to all parts of the records designated above, which may include psychiatric information, alcohol, and/or drug abuse history, HIV/AIDS diagnosis, or any other records of a sensitive nature.

This Authorization shall remain in effect until one year from the date of the signature. I understand that I may revoke this authorization at any time by notifying the office in writing. However, I understand that it will not impact any action taken before receiving the revocation.

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

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Date

2500 W. Lake Mary Blvd, Suite 110 Lake Mary, FL 32746
Phone: (407) 906-8843 Fax: (888) 335-7778