Gerard Chambers Jr. Psy.D. Ph.D.
Clinical Neuropsychologist PSY #23778

Neuropsychological & Forensic Assessment Services

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I authorize, Gerard Chambers Psy.D., Ph.D., Clinical Neuropsychologist PSY #23778 to **obtain & release** information for the following patient:

Patient Name/Print Legibly: ____

X Pertinent treatment information
X Results of neurological evaluation/medical diagnoses
X A Summary of treatment records
X Discharge Summary
X Neurological/Medical summary including course, severity, diagnostics, psychosurgery, outcomes and prognosis, imaging procedures/outcomes **if applicable.**

This information should only be obtained from/released to the following provider/s:

Provider/s Name/Facility Name Here: ____

<u>This Authorization shall remain in effect for one calendar year from the signature date below:</u>

**I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that the psychologist has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance 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. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

______________________	______________________	____________
Signature of Patient/Parent	Print Patient Name Legibly	Date Signed

______________________	______________________
Guardian	Print Name