Gerard Chambers Psy.D., Ph.D.
Clinical Neuropsychologist #23778

Neuropsychological Assessment Services Authorization of Release

Email: gerard@drgchambers.com Phone: 321.208.1554 Fax: 831.325.0125
1500 41st Ave. #254A Capitola, CA 95010 & 1120 McKendrie St. San Jose, CA 95126

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

Patient Name/Date of Birth: ____

Reason for Release: Entire medical/psychological/counseling file to Dr. Chambers via fax or email including but not limited to:

X Treatment information
X Diagnostic Information
X Record Summary
X Test Results
X Discharge Summary
X Biographical History

Provider Name:	Provider Email/Fax Number:

<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 {if applicable} Print Name