

KAROL NEUROPSYCHOLOGICAL SERVICES
11800 SINGLETREE LANE #203 EDEN PRAIRIE, MN 55344
Ph: (952) 944-5502 / Fax: (612)568-4977

This form when completed and signed by you, **authorizes the party below to provide protected information from their records** to Karol Neuropsychological Services (Brain Health Group, LLC). It also authorizes Karol Neuropsychological Services to release protected information from your clinical record to the party listed below.

I hereby **authorize the party named below to provide copies of my protected health information** including all information or only medical, health, psychological, psychometric with test scores and protocols. psychiatric, abuse, mental health, chemical dependency, vocational, academic, police, insurance, legal, and court records for all purposes or only: health care, vocational, academic, legal, insurance purposes to Karol Neuropsychological Services. If any boxes other than all are checked then only that box applies.

I also hereby authorize Karol Neuropsychological Services to provide copies of my protected health information including all information or only medical, health, psychological, psychometric, psychiatric, abuse, mental health, chemical dependency, vocational, academic, police, insurance, legal, and court records for all purposes or only: health care, vocational, academic, legal, insurance purposes to the party listed below. If any boxes other than all are checked then only that box applies.

A copy or fax of this document shall be as valid as the original. Release under this authorization includes, but is not limited to, oral communication between Karol Neuropsychological Services and the below named party of opinions, interpretations, or information supplemental to written records or otherwise.

Information should only be released to/exchanged with person/facility/address:

I am requesting Karol Neuropsychological Services to release/exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are our patient and you do not desire to state a specific purpose.) At the request of the individual (if other is marked this box is invalid) other _____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

One year (if other is marked this box is invalid) other: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Karol Neuropsychological Services mailing address. However, your revocation will not be effective to the extent that Karol Neuropsychological Services has taken action in reliance on the 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. You should refer to the Notice and the Services Agreement you were given for further information.

I understand that Karol Neuropsychological Services 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 the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Print Patient Name	Date of Birth	Signature of Patient/Parent/Legal Appointee	Date
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If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.