

# THE NEURODEVELOPMENT RESOURCE CENTER

DAVID E. NILSSON, PH.D., ABPP-CN

## Release of Information Authorization

\*The signed release of information is valid for one year unless otherwise revoked through written notice.\*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Parent / Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give my permission to the office of David E. Nilsson, Ph.D., ABPP-CN to release and / or obtain information concerning the patient's evaluation or consultation, diagnosis, personal history, treatment and examination.

By my signature, I release Dr. David E. Nilsson to:

- Release my records to:      Name: \_\_\_\_\_
- Obtain my records from:      Business Name: \_\_\_\_\_
- Permission to Consult with:      Address: \_\_\_\_\_  
\_\_\_\_\_
- Other: \_\_\_\_\_      Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

The PHI (personal health information) contained within this document is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services for this patient. Any other use is in violation of Federal Law (HIPAA) and will be reported as such.