Stixrud GROUP
A Neuropsychology Practice

AUTHORIZATION FOR
WRITTEN AND/OR ORAL RELEASE OF INFORMATION

I, _____, hereby authorize _____
(self, parent, or guardian) (Doctor's name)

of The Stixrud Group, LLC to exchange information and collaborate with the people

listed below in order to best serve the needs of _____,(.)
(relation to client or self)

_____,
(client)

Date(s) Tested: _____

Please provide complete information for each recipient designated below. While we do offer a password-protected, electronic (email) option, please be advised that standard mail is generally still a more secure method of delivery.

Recipient 1:
Communication type (check one): ___ oral only ___ written only __ both

Send written report by (check one) : ___ email ___ fax ___ postal mail __ N/A

Name: _____ Title: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Recipient 2:
Communication type (check one): ___ oral only ___ written only __ both

Send written report by (check one) : ___ email ___ fax ___ postal mail __ N/A

Name: _____ Title: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Recipient 3:
Communication type (check one): ___ oral only ___ written only __ both

Send written report by (check one) : ___ email ___ fax ___ postal mail __ N/A

Name: _____ Title: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Recipient 4:
Communication type (check one): ___ oral only ___ written only __ both

Send written report by (check one) : ___ email ___ fax ___ postal mail __ N/A

Name: _____ Title: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

PLEASE INITIAL ONE OF THE FOLLOWING:

----- Release report only after I have read it, per Signed Authorization for Release form.

----- I waive my right to read the report before it is released to persons indicated on the Signed Authorization for Release form and understand that it will be simultaneously released to both the persons indicated and myself

By completing this form, The Stixrud Group, LLC is released from all legal liability that may arise as a result of their compliance with my request.

Please be advised that this authorization will remain in effect for the course of the evaluation process, not to exceed twelve months from the date indicated on the form, unless we receive a written request to revoke this authorization.

_____ _____

Signature of Client (parent/guardian, if minor) Date

*This consent is valid for the period indicated not to exceed one year.