Johnson Neuropsychology, PLLC

Request/Authorization for Release of Information

Patient:

Address:

Phone: Date of Birth:

I give my permission to <u>Johnson Neuropsychology, PLLC</u> to exchange information relating to my/my child's medical, educational, and mental health between staff and:

1. Name:
   Address:
   Phone:
   Fax:

2. Name:
   Address:
   Phone:
   Fax:

3. Name:
   Address:
   Phone:
   Fax:

Patient Name (Printed):_____

Patient Signature (or parent/guardian if patient is a minor):_____

Date:_____