

# Pediatric Neuropsychological Services of Alaska, PC

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Pediatric Neuropsychological Services of Alaska, PC provides evaluation and treatment for children. In order to complete our evaluation and to provide the best clinical care possible, we need to gather and share information about your child with individuals and organizations. This occurs both through verbal communications and written communication, including faxes and written reports.

This release is intended to authorize the staff of Pediatric Neuropsychological Services of Alaska, PC to receive information from and share information with (verbal and written) individuals and organizations.

## Demographics

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Home Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

## Information Requested & Information Shared

*I authorize the release and sharing of the following information of the child named above between the staff of Pediatric Neuropsychological Services of Alaska, PC and the individuals/organizations listed below.*

Information Requested:

\_\_\_\_\_  
\_\_\_\_\_

Information Shared:

\_\_\_\_\_  
\_\_\_\_\_

Purpose of Release: \_\_\_\_\_  
Restrictions and/or Exclusions (if any): \_\_\_\_\_

## Gather and Share Information

*I am requesting the above information from the following individuals and organizations; and, I am authorizing the staff of Pediatric Neuropsychological Services of Alaska, PC to release the above information to the following individuals and organizations.*

Name/Facility	Requesting Info	Disclosing Info
_____	_____	_____
Attention _____	Telephone _____	
Address _____		
City _____	State _____	Zip _____

Name/Facility \_\_\_\_\_ Requesting Info \_\_\_\_\_ Disclosing Info \_\_\_\_\_  
Attention \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Facility \_\_\_\_\_ Requesting Info \_\_\_\_\_ Disclosing Info \_\_\_\_\_  
Attention \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Facility \_\_\_\_\_ Requesting Info \_\_\_\_\_ Disclosing Info \_\_\_\_\_  
Attention \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*I hereby authorize the staff of Pediatric Neuropsychological Services of Alaska, PC to obtain information from and share information with the above named individuals and organizations as requested. This may include information about academic performance and testing, drug and alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that the staff of Pediatric Neuropsychological Services of Alaska, PC cannot control how the above named individuals use or share the information, and that laws protecting its confidentiality at Pediatric Neuropsychological Services of Alaska may or may not protect this information once it has been shared with these individuals and organizations. Information will not be provided to or shared with by the staff of Pediatric Neuropsychological Services of Alaska, PC without a valid signature below. This authorization will expire one year from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that the above named individual or organization has already received or shared the information. I understand that Pediatric Neuropsychological Services of Alaska, PC will continue to provide care, even if I do not authorize this release.*

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent of legal guardian signature is required for patients under the age of 18 without emancipated status or a special condition.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date \_\_\_\_\_