SCNEURO
W. Howard Buddin Jr., Ph.D.
Neuropsychologist | Licensed Clinical Psychologist

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

SSN: _____ Date(s) of Service: _____

Information requested/being sent: _____

Purpose of Disclosure: _____

I request and authorize W. Howard Buddin Jr., Ph.D. to (select one) ☐ release ☐ receive ☐ release and receive my relevant healthcare information from/to:

Name: _____

Address 1: _____

Address 2: _____

City: _____

State: _____ ZIP: _____ Fax/email: _____

I understand that:

- This information may include reference to psychiatric care, sexual assault, alcohol abuse and/or drug abuse and results of tests for all infectious diseases including AIDS/HIV.
- This authorization is effective for 365 days, but that I have the right to revoke authorization at any time by notifying SC Neuro/Dr. Buddin's office in writing.
- Revocation will not apply to information that has already been released in response to this authorization.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Authorizing the disclosure of this private health information is voluntary and that I can refuse to sign this authorization.
- I may inspect or obtain a copy of the information to be used or disclosed.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient or Legal Representative | Relationship to Patient, if signed Legal Guardian/Representative

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