Nancy Leslie, Ph.D.
Clinical Neuropsychology
9252 Brookwater Circle
College Station, TX 77845
Tel. (979) 774-1000

Release of Information—Patient Authorization

Patient Name: ____ DOB:_________________

1. I authorize Nancy Leslie Ph.D to use, disclose to, receive from or exchange with individuals or entities identified in Item # 5, the above named individual's protected health information (PHI).
2. The individual(s) or organization(s) identified in Item # 5 are authorized to make the disclosure.
3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated). I understand that the information disclosed may be in different format than requested.

- ☐ Entire Record
- ☐ Neuropsychological or Psychological Evaluation
- ☐ Psychotherapy Notes
- ☐ Patient History Questionnaire
- ☐ Other: ____

4. I understand that the information in my health records may include information relating to behavioral or mental health services, psychological treatment and/or treatment for alcohol and drug abuse. It may also include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
5. The information identified above may be used by or disclosed to or received from or exchanged with the following individuals or organization(s):

Name: ____

Name: ____

Name: ____

6. This information for which I am authorizing disclosure will be used for the following purpose:
   - My personal records
   - Sharing with other health care providers as needed
   - Other: ____
7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Leslie. I understand that the revocation will not apply to information that has already been released in response to this authorization.
8. This authorization will expire after: ______________. If I fail to specify an expiration date or event, this authorization will expire 12 months from the date on which it was signed.
9. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

Signature of Patient or Legal Representative: ___________________________Date:__________

If signed by legal representative, relationship to patient: _______________________________