Karen Burk Paull, Ph.D.
Cleveland Child Neuropsychology Services, LLC
3659 Green Road
Beachwood, OH 44122

AUTHORIZATION FOR RELEASE OR USE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

I, _____, authorize Dr. Karen Paull's office to obtain, use, and disclose protected health information regarding the above named client, with the individuals or entities listed below for the purposes of completing a neuropsychological evaluation and assisting in the provision and coordination of care. This authorization includes written, verbal, and email communications and will expire one year after the date I sign it.

Name:	Phone:
Address:	Fax:
Name:	Phone:
Address:	Fax:
Name:	Phone:
Address:	Fax:

The specific health information to be obtained and/or disclosed:

- ☐ School records and observations, including special education information (e.g., MFE, IEP, Service Plan)
- ☐ Medical records, including patient histories, office notes, test results, radiologic studies, discharge summaries and records sent by other health care providers

  This may include (please initial) : ____ Alcohol/Drug Treatment Information

  ____ Mental Health Information

  ____ HIV Related Information

  ____ Other _____

- ☐ Other (specify): _____
- ☐ Neuropsychological evaluation findings and report

Client/Legal Guardian Signature _____

Date: _____