t: 215-826-3301 f: 215-798-9647
e: info@neurogenicss.com

Authorization to Exchange, Obtain or Release Information

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I_____(patient or family member) hereby grant NeurogeniCSS permission to communicate with the following person and/or facility:

Name: _____

Contact Information: _____

INFORMATION TO BE RELEASED:

☐ Medical History
☐ Therapy Evaluation
☐ Treatment Notes
☐ Physician Records (Evaluations, physician notes, diagnostic reports, etc.)

FOR THE PURPOSE OF (*please check all that apply*):

☐ Coordinating care with other professionals
☐ Providing continuity of services
☐ Updating therapeutic progress
☐ Other _____

☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email and/or fax.
☐ I understand that unless revoked, this authorization will remain valid until/unless written revocation is presented.

_____ _____
Print Name Date

_____ _____
Signature Relationship to Patient