Mountain
Memory Assessment

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Authorization to Release Protected Information

This form, when completed and signed by you, authorizes Mountain Memory Assessment to release protected health information from your clinical record to the person you designate.

I authorize **Mountain Memory Assessment** to release the following information:

_____

Only to the following individual(s) or organization(s):

Name: _____ Telephone: _____

Address: _____ Fax: _____

_____

_____

I am requesting Mountain Memory Assessment release this information for the following reason(s):

_____

This authorization shall remain in effect until _____/_____/_____. Although I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Mountain Memory Assessment mailing address above, I understand that my revocation will not be effective to the extent that they have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that they generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. Further, I understand that information used or disclosed pursuant to the authorization could be disclosed by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of client or guardian Date

_____ _____

Relationship / authority to act (if not client) Witness